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ABSTRACT

Presented is the second year report of a project designed to assist state advisory councils in evaluating services to the developmentally disabled. Described are the five project objectives (including providing assistance to new and existing regional committees), methodologies and results (including definition of services and questions to be asked in evaluating services), and dissemination and utilization of results (through such means as slide tape materials). Three appendixes comprise the bulk of the document. Fifty four services for the developmentally disabled are defined and grouped into 11 clusters (including identification and assessment, treatment and family support services). Provided are Oregon data reports (including measures of service availability and quality) and recommended objectives for eight of the defined service areas. The objectives adopted by three task forces for state implementation are ranked according to priority, and a rationale for each priority assigned is included. (CL)

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WORKING PAPER NO. 79

A Planning and Evaluation Strategy for State Developmental Disabilities Councils: Volume II.

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August, 1974

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INTRODUCTION

The Developmental Disabilities Services and Facilities Construction Act (Public Law 91-517, 1970) was designed to provide states with broad responsibility for planning and implementing a comprehensive program of services for developmentally disabled people. The act also authorized the provision of formula grant funds to stimulate the construction of facilities and the development of services for people who are handicapped by the conditions of mental retardation, cerebral palsy, epilepsy, and other neurological disorders requiring similar services and treatment.

In order to receive federal funds under this program, it is necessary for a state to establish a planning and advisory council whose responsibility it is to prepare annually a comprehensive plan for meeting the needs of the state's developmentally disabled citizens. While the responsibilities are delineated by the legislation, the methods for engaging in comprehensive planning and evaluating have not been clearly described.

The mandate to state DD councils with respect to evaluation is especially far reaching and complex. Each council is required to assess how well existing services meet the needs of the developmentally disabled people in its state. This requires that the council have available two kinds of information. First the council needs to know how many clients need what kinds of services in various parts of the state. Secondly, it is necessary to know what services and resources are currently available to respond to those needs. Where gaps exist between need and resources, the council's annual plan should be directed toward narrowing the discrepancy. A strategy must be developed for integrating these tasks. Since the usefulness of any strategy depends upon how well it can be understood and utilized, training procedures and materials must be developed to acquaint council members with the strategy and their role in its implementation.

During the last two years, the Research and Training Center in Mental Retardation at the University of Oregon has had the opportunity to collaborate with the Oregon DD Council on a project which addressed these issues. The basic purpose of the project has been to investigate a strategy that can be employed by State DD Councils to meet their responsibilities with respect to planning and evaluating.

During the first year progress was made in the areas of needs assessment, utilization of regional committees, prioritization of goals, and description of an overall strategy for understanding and implementing the legislated responsibilities of the state DD councils. The objectives for the year were approached through a series of activities that included two workshops for the state council, individual workshops for regional committees, and a statewide survey of practitioners and experts in the field of developmental disabilities. Center Working Paper No. 71 offers a full report on the first year's activities along with instructional materials which can be used to implement the processes developed during the year.

The strategy that was developed at that time involved three inter-related components: Planning, influencing, and evaluating--sequential activities in which a state council must engage to fulfill the legislated mandate. Planning involves the establishment of goals, the assessment of needs and resources, the identification of gaps in service delivery, and the selection of objectives which are aimed toward the achievement of the goals. Influencing is the vehicle through which a council implements its objectives; lacking direct control over most programs, the council engages in activities that will lead the responsible agencies to improve the delivery of services in accord with the goals and objectives of the state plan. Evaluation is carried out in two ways: (1) the state council must evaluate the extent to which the state's service delivery system meets the needs of developmentally disabled people in the state; (2) the council annually must evaluate the accomplishment of its own objectives. Evaluative information leads to the selection of new objectives and the cycle begins again.

PROJECT OBJECTIVES

The efforts of the second project year were directed toward developing and implementing evaluation methodologies and clarifying further the issues that are involved in the cyclical process of planning, influencing and evaluating.

In a general sense, the outcome of this project is the description of a two-year planning cycle which takes the Council from general goals based on perceptions of need through systematic data collection and interpretation to specific objectives for action. Accomplishing this required the close collaboration of the Oregon DD Council with the Research and Training Center project staff. The specific objectives for the year were:

1. Provide assistance to new and existing regional committees.
2. Develop procedures for evaluating services provided to DD clients in the state.
3. Explore the development of task forces to assist the State Council in implementing the strategy.

4. Collect data relating to the priorities of the 1974 State Plan and provide data for the generation of objectives for the 1975 State Plan.

5. Develop and implement procedures enabling the State Council to update objectives and priorities for inclusion in the 1975 State Plan:

   a. generate recommendations for objectives (alternatives);
   b. select and prioritize objectives;
   c. provide models for implementation.

METHODOLOGIES AND RESULTS

The methodological activities of this project resulted in the description of processes as well as specific products which emerged after implementing these processes. Each of the objectives delineated for the project required several activities which, for the most part, were carried out cooperatively by the R & T project staff and the Council (staff, task forces, and/or the Council's Executive Committee).

Objective 1: Establishment of Regional Committees

Proposed activities related to this objective included assisting in the development of five new regional committees, conducting goal setting workshops, and providing consultation to new and existing regional committees. Concurrent with the second year of the project, however, the Oregon DD Council began to raise some questions and concerns about roles and responsibilities of regional committees. Many questions were raised about the relationship between state and regional committees and the feasibility and purpose of establishing regional DD committees. Because of the concerns, the project staff believed that action on the first objective would be inappropriate until the problems were resolved and the State Council had established its policy. At the end of the project year, some decisions had been made by the Council. It has now endorsed the concept of regional planning bodies and has made decisions on the administrative structure which will link the regional committees to the State Council and the major implementing agency. The questions of roles, responsibilities, and staff support have yet to be answered.

Objective 2: Developing a Methodology for Evaluating Services

Definition of Services. The transition from the first project year, which responded to the planning function, to the second year, which focused on evaluation, required some specific changes in conceptualization. It was necessary to study Oregon's 1974 State Plan and isolate the services which were addressed in each of the eleven goals that had been adopted. This activity revealed twenty-two discrete services which were of concern to the State Council at that time. With this list as a catalyst, the project staff reviewed other documents for the purpose of developing a comprehensive list of major services which might be needed by a developmentally disabled person over a lifetime. Once the delineation of services was completed, each service was defined so as to be identifiable, measurable, and non-duplicative of any other service listed. These definitions are presented in Appendix A of this report.

Questions To Be Asked in Evaluating Services. Once the services were defined, it was necessary to determine conceptually what considerations are essential to an evaluation of services. Three basic components were identified: quantity, quality and effectiveness. In evaluating the quantity of a service, the following information was regarded as important: the number of facilities or programs which offer the service; where they are located; how many clients are being served; how many can be served (capacity and rate of movement through a given type of service); and how many clients need the service in different regions of the state. An assessment of quality of the service required information about the existence of standards for the service, the content of standards, and their enforcement (how many facilities or programs meet the standards and how does the agency assure that they are met). Effectiveness of a program is measured by determining the success of the program in meeting clients' needs. This information is probably the most important but the most difficult type of data to gather.

Types of Objectives Suited to State Council Planning. The third task related to conceptualization of the strategy was the description of the types of objectives which are suitable for potential adoption by State DD Councils. Five types of objectives were identified as being important: agency objectives (addressing policies and procedures of public and private agencies who serve DD clients); legislative objectives (attending to federal or state legislation that affects DD clients and/or services to them); funding objectives (guiding the utilization of DDSA and other discretionary funds for the improvement of services to DD clients); study objectives (reflecting the need to examine in depth the dimensions of a particular problem); and data base objectives (speaking to improvements in the data that are provided by agencies). The agency, legislation, and funding objectives relate primarily to the Council's role of influencing. Data collection objectives relate primarily to the evaluation responsibility. All five types of objectives provide the foundation for planning.

Objective 3: Development of Task Forces

The third objective involved two major activities: (1) determining the responsibilities and the most effective composition of task forces; and (2) establishing working task forces to the Oregon Council and providing training to task force members. The first activity required an analysis of how a task force may be used as a working arm of the State Council in each of the basic functions--planning, influencing, and evaluating. Consideration was also given to the kinds of information that various task forces would need as they attempted to perform their tasks.

The composition of the Oregon task forces was developed out of consideration of the scope of evaluation to be conducted during the year. Early in the second year of the project, specific services were selected for evaluation across the state. The selection of services was based on the 1974 State Plan. (Fuller discussion of service selection is presented above, Objective 2, Definition of Services.) The analysis of the 1974 State Plan revealed that 22 distinct services needed to be addressed by task forces. The 22 services could be sorted into 3 clusters: identification and assessment; pre-school, school-aged, and family services; and adult services. Consequently, three task forces were established for the purpose of receiving and interpreting data related to each of those areas.

Each task force was chaired by a Council member and included in its membership both council and non-council people. The membership of each task force was structured in such a way as to insure representation by those agencies which were responsible for providing services in the cluster being evaluated. There were two purposes for organizing the task forces in this way. The individuals who work in the service-providing agencies brought useful information to the task force meetings. They acted as a resource supplementing the data being collected by the staff. Ideally, they would be representative of their respective agencies, presenting in an informed and authorized way the views and plans of their agencies. In addition, the agency's representation on task forces during the evaluating and planning stages established vehicles which could later be used for influencing the agency. The task force members carried back to their agencies information about the goals and the activities of the Council. Having been actively involved in the planning, they became friendly in-house voices for the DD Council.

The task forces met during the first half of the year to assist in determining types of data to be collected later in the year, to make recommendations about methodology for data collection, and to participate in the development of service definitions. Once data collection began, the task force members monitored the process to some extent and also acted as a point of contact for their agencies.

The final phase of task force involvement in the project, the most time consuming and critical point of participation, occurred after the data had been collected and compiled. It was then the job of the task forces to study and interpret the data and recommend to the Council specific objectives for action during the next year.

Objective 4: Collecting and Communicating Data

Assessment of Needs and Resources. Before the task forces could attend to the task of developing and recommending objectives, it was necessary to collect and organize information about the current status of service delivery to developmentally disabled clients. Responsibility for this effort was assumed by project staff, although it was recognized that the DD Council itself would ultimately have to assume this role.

Two types of data were sought: (1) data about the existing services in the state as they are monitored by state agencies; and (2) perceptions at the local level as to the availability and need for each type of service. The second type of information was requested of county mental health program directors and service coordinators.

Requests for information about the status of existing services were made of all state agencies responsible for providing or monitoring services to developmentally disabled people. This included the Mental Health Division, which is primarily responsible to the target population, as well as the Vocational Rehabilitation Division, Children's Services, Public Welfare, Employment Service, State Board of Education, Parks and Recreation Branch of the Highway Department, Crippled Children's Division, Health Department, and the major private service agencies.

Contact was made with appropriate agencies, frequently through Council or task force members. An accountable person in each agency was sought who would assume responsibility for communicating data from the agency to the research staff. After identifying an appropriate agency contact, data were collected through mailed questionnaires. Ongoing contact by phone was maintaned with each person responsible for the provision of data.

Responses from the state agencies were of mixed quality. A few of the agencies had program and/or client monitoring systems which allowed them to identify with reasonable accuracy the particular services being provided to developmentally disabled clients and the characteristics of the clients who received the services. Some agencies did not identify clients by disability but provided data on facilities and standards and occasionally offered estimates on number of DD clients served in different geographic areas. Some agencies which did not have accessible client data were also not able to indicate which facilities provided service to DD clients (as with foster care). For some services, standards have been developed and implemented; for others they were only in a stage of development. Still others reported no standards at all (counseling, for example).

The ability of an agency to respond to data inquiries and the completeness of the response provided useful information to the task forces. When deficiencies were noted, this frequently led to the generation of data collection objectives to be considered for inclusion in the 1975 State Plan.

Communication of Data to the Task Forces. Two activities involved in the communication of data were the development of a useful reporting format and the actual compilation and reporting of the data to task forces. The format for the report was based on the conceptualization of service categories and the issues addressed in the evaluation survey. Various formats were presented to the task forces, and modifications were made in response to their suggestions so that the final form would convey the evaluation data in a useful way.

A report was prepared for each of the service clusters for which data had been collected. The same format was used for each report, whenever possible, in order to facilitate ease of interpretation.

The location of facilities providing each service was displayed on a map of Oregon to provide a vehicle for quickly assessing the distribution of services across the state. The number of clients receiving each service was presented in terms of geographical distribution, using a ratio of clients served to total population within regions as a standard for comparison. The need for each service was presented in terms of the surveyed perceptions of service coordinators and community mental health program directors. Data on standards were presented in a narrative form. Reproduction of these reports can be found in Appendix B of this report.

Objective 5: Oregon's 1975 State Plan

Generation of Alternative Objectives. After collecting data and presenting reports to the task forces, attention was directed toward the generation of objectives. Having received and studied the reports on services included in their area of concern, the participants first proposed objectives in a "brainstorming" fashion. They then reacted to what had been proposed, refined some, eliminated others, and made a final selection of objectives to be presented to the Council.

Task forces generated five types of objectives: agency, legislative, funding, study, and data collection. Examples of the objectives recommended by one task force can be found in Appendix B after the first data report. In all, over 100 objectives were recommended to the State Council for its consideration.

Selecting Objectives for State Plan. The selection of objectives and the setting of priorities for the State Plan was the responsibility of the full Council. In order to make the final selection of objectives to be given high priority status in the 1975 State Plan, it was necessary for the Oregon Council to study the data reports and recommendations. Each Council member received service definitions, data reports, and recommended objectives as preparatory materials for a planning workshop. The purpose of the workshop was twofold: (1) to set priorities for the 1975 State Plan, and (2) to adopt a procedure for implementing the Plan.

During the first day of the workshop, each set of objectives was considered separately. The agency objectives were presented within service clusters--one set of objectives for each cluster. The other types of objectives were presented across service clusters, yielding one set of objectives in each of the following areas: legislation, funding, data collection, and study.

The entire first day of the workshop was devoted to reviewing, clarifying, and rating the objectives in each set. No argumentation was made at this time regarding the merit of the separate objectives. Each Council member individually rated each objective on a four-point scale reflecting the extent to which he preferred that the Council put resources into trying to accomplish the objective during the next year. Each Council member was also able to use a "0" rating to indicate total rejection of an objective.

Once the Council members had concluded their individual ratings, the results were tabulated and displayed. The objectives were ordered according to the mean score of the ratings. Where ties appeared in the mean score, the objectives were ordered by the frequency distribution.

During the second day of the workshop, Council members were presented with the results of the first day's efforts. The format of the second day allowed Council members to debate the order of items within the following constraints. Recommended changes were entertained where a Council member had serious concern about the relative placement of one or more objectives and wanted to suggest a significant alteration in the order. When such a recommendation was made. argumentation occurred, structured by strict rules of debate agreed to by all members at the opening of the session. At the conclusion of debate on a given recommendation, voice or hand vote determined the passage or defeat of a recommended change. All serious concerns were heard, debated, voted on, and when this process was completed, the revised lists were ratified by the full Council for inclusion in the 1975 State Plan. The prioritized objectives are included in Appendix C of this report. The accompanying charts show the results of the ratings made the first day of the workshop (mean score and frequency distribution) and the outcomes of the second day when priorities were reordered.

Plans for Implementing Priorities. The third major session of the workshop was devoted to discussing plans for implementing the various types of objectives. The recommendation of the project staff suggested that separate, permanent task forces should be organized for each of the ten service areas and should be charged by the Council with the following responsibilities:

1. to carry out agency objectives relevant to its service area. This means developing a plan or strategy for influencing agencies, directing the implementation of that plan, and preparing a report at year's end on the degree of achievement of the agency objectives;

2. to analyze the state plans of various public agencies with respect to their involvement in its service area;

3. to interpret and report all relevant data on the quantity, quality, and effectiveness of services contained within a particular service area; and

4. to develop and recommend to the State Council one year later five different kinds of objectives relevant to its service area for inclusion in the 1976 State Plan and for guiding its subsequent activities.

In addition to the ten service area task forces, it was recommended that the council establish (or retain) four standing committees: socio-legal (addressing legislative objectives), funding (recommending funding priorities and seeking out new sources of funds), data management (working with state agencies to improve the multi-agency data system), and study (implementing the study objectives). These recommendations were adopted by the Oregon Council with minor modifications at the conclusion of the workshop.

Having made decisions during the workshop regarding what issues to address over the next year and how to implement strategies for influencing, evaluating and planning, the Oregon Council completed the second phase in the cycle of planning. The processes employed over the two years, the involvement of the Council members during the workshop, and the structures laid out for next year's work build a system which will permit the council, with the necessary supportive staff, to carry out its responsibilities to developmentally disabled people in Oregon.

DISSEMINATION AND UTILIZATION OF RESULTS

The results of this project have been disseminated through a variety of reports and presentations. The results of the project's first year have been presented in Center Working Paper Number 71. This paper was distributed to all chairpersons and staff of DD Councils throughout the country. The results of the project's second year are presented in this paper. The R & T Center will provide both papers to interested parties upon request. The reports have also been made available to the Developmental Disabilities Technical Assistance System (DDTAS) at the University of North Carolina for further distribution upon request.

DDTAS provides a vehicle to the R & T Center for assisting interested councils in the utilization of information from this project in their own states. Contacts have been made with several states through DDTAS and on-going communication will continue. The Research and Training Center will continue to respond to request for consultation from Regions IX and X directly and from other regions through DDTAS.

While the purpose of the project was to develop planning procedures for state Developmental Disabilities Councils, the findings of the project have application to other agencies as well. The methodologies of the second year can be generalized for planning by other systems which find themselves in the influencing rather than controlling role. The Oregon Association for Retarded Citizens, for example, used these processes to develop a five-year state plan.

Sub-elements of the materials presented here can be drawn out for use in other contexts. The definitions of services have application to data collection systems for social service agencies in general. They have proved useful in the development of a Mental Health Information System in Oregon and to some local DD service coordinators in their data collection efforts.

The slide tape training materials developed as part of this project provided a useful vehicle for DD council training. They help council members understand the role of the DD Council and present a framework for carrying out council responsibilities. Using the material in the working papers in conjunction with the slide tape, a council can become acquainted with methodologies which can be modified and implemented to achieve coordinated planning, influencing and evaluating.

The impact of the project as a whole on the Oregon Developmental Disabilities Council demonstrates the applicability of the materials. The Oregon State Council has utilized the methodologies over the last two years in the development of its state plan. The Council has committed itself to continuing the process by establishing task forces to carry out the responsibilities of planning, influencing, and evaluating services to developmentally disabled citizens.

Implementation by Developmental Disabilities Councils of the planning and evaluation procedures developed in this project could have major impact on three aspects of programming for the developmentally disabled: (1) the major public and private agencies within the state could be influenced by a more articulate plan into providing a higher level of service to developmentally disabled clients; (2) monitoring systems could become more accessible and integrated in order to provide to planning bodies essential information about services and clients; (3) specially funded projects (DDSA formula grant monies) could be more appropriately selected in order to meet the state's highest expressed priorities.

References

Eidell, T. and Nagle, J. SPECS Orientation Workshop Materials. Washington, D. C.: General Learning Corporation, 1973.

Halpern, A., Fox, K., and Nagle, J. A Planning and Evaluation Strategy for State Developmental Disabilities Councils: Volume I. Working Paper No. 71, August, 1973.

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APPENDIX A

SERVICE DEFINITIONS

The essential information which should guide the activities of the State DD Council is the body of data that can be collected regarding the quantity, quality, and effectiveness of a variety of services that are provided to developmentally disabled individuals and their families. During the past year, an effort has been made to identify and define the most important of these services. In all, 54 discrete services have been defined and sorted into 10 clusters of direct services and one cluster of indirect services. The former refers to services that are provided directly to developmentally disabled clients or their families. The latter are services that are provided to other people (e.g., teachers, employers, physicians) which, if effective, have a significant and beneficial impact upon the lives of developmentally disabled people and their families.

Two major criteria were followed in developing each of the definitions: (1) The defined characteristics of each service must be discrete and unique, not overlapping with the characteristics of other defined services; and (2) The services must be defined in a way that makes them reportable by either agencies or individuals who claim to provide the service. When these two criteria are followed, it enhances the possibility of making agencies and individuals accountable for the manner in which they provide the service.

A number of resources were utilized in the development of the 54 definitions. The goals and priorities included in Oregon's 1974 State Plan were the starting point of this endeavor. Additional resources included the 16 services as defined by federal developmental disabilities legislation, service definitions that have been prepared by the Oregon Mental Health Division, the glossary of the new Manual on Terminology and Classification in Mental Retardation published by the American Association on Mental Deficiency, and Standards for Community Agencies Serving Persons with Mental Retardation and Other Developmental Disabilities published by the Accreditation Council for Facilities for the Mentally Retarded. This latter resource was particularly helpful in providing material for many of the definitions.

Several individuals and groups were involved in critical reviews of the definitions: task forces of the Council, service coordinators, and representatives of the major state agencies. They studied the list in terms of its completeness, appropriateness of grouping, and clarity and useability of definitions. The work of each group brought about significant refinements in the delineation of the services and in the substance of the definitions. Staff from the Oregon Mental Health Division and personnel from other state agencies participated in the review and development of the list with the hope that the final product might be useful to the development of a statewide, multi-agency information system.

Where other sources have contributed to the content of a definition as it is offered here, the source(s) has been documented immediately after the definition. In some cases two or more sources were used (and so documented); occasionally the same material was found in more than one source (all are documented).

The following codes were used to reference the resources:

JCAH[1] - Joint Commission on Accreditation of Hospitals, *Standards for Community Agencies*, 1973.

JCAH[2] - Joint Commission on Accreditation of Hospitals, *Standards for Residential Facilities for the Mentally Retarded*, 1971.

AAMD - American Association on Mental Deficiencies, *Manual on Terminology and Classification in Mental Retardation*, 1973.

CLS - University of Oregon; School of Health, Physical Education, and Recreation; Center of Leisure Studies.

Taber - C. W. Taber, *Taber's Cyclopedic Medical Dictionary*; F. A. Davis Company, 1963, Philadelphia.

MHD - State of Oregon Mental Health Division, MR/DD Section.

HEW - HEW Guidelines for Services and Programs for Developmentally Disabled Persons; May 1972.

C.K.S. - Sigelman, C. K.; ed., *Protective Services and Citizen Advocacy*. Research and Training Center in Mental Retardation, Texas Tech University, Lubbock, Texas, 1974.

RT - Research and Training Center in Mental Retardation, University of Oregon.

Definitions of Services for Developmentally Disabled Citizens

1.0 GENERAL SUPPORTIVE SERVICES

The discrete services in this cluster provide the client and his family with support and assistance in finding and securing the various services that they need throughout their lives. Ideally, services 1.1 through 1.4 will be provided by a single agency in order to insure continuity of services to clients with a minimum of confusion.

1.1 Casefinding: The process of systematically reaching into the community for the purposes of identifying persons in need of services; alerting persons and their families to the availability of services; and assisting persons to enter the service delivery system. (JCAH1)

1.2 Information and Referral: The development and use of a resource catalog and retrieval system which can supply information about, and referral to, appropriate community resources. This information must be made available to any individuals who request help and whose needs can properly be met in this way. (HEW)

1.3 Coordination of Services: The process by which responsibility is established for implementation of the client's individual program plan at a given point in time. This process includes providing support to the client, procuring direct services, coordinating the services of different agencies, and monitoring the progress of the client. (JCAH[1])

1.4 Follow Along: The establishment and maintenance of regular communication on a life-long basis with clients and their families, as they desire, for the purpose of assuring that changes in their needs for service are recognized and appropriately met. (AAMD, JCAH[1], HEW)

1.5 Protective Services: A system of professional services that monitors programs, and that assists disabled persons in securing their general and specific rights. Assistance is rendered by providing advice and guidance and, if necessary, by actively intervening in social and legal processes to safeguard the rights of the developmentally disabled by assuring that they receive appropriate services and by preventing their abuse. (JCAH[1], C.K.S.)

1.6 Personal Advocacy: The provision of a competent citizen to assist and befriend an impaired person in coping with his problems; providing help and affection in a one-to-one relationship. One desired outcome of this service is to enable the impaired person, whenever possible, to become his own advocate. (JCAH[1], AAMD)

1.7 Guardianship Services: The determination of whether or not an impaired individual requires personal or property guardianship, followed by assistance in the procurement of guardianship when appropriate. (RT)

2.0 IDENTIFICATION AND ASSESSMENT

The discrete services in this cluster are aimed at identifying people from the general population who might be developmentally disabled, and then following through with specific assessment procedures to pinpoint the nature of the disability and develop recommendations for specific services that are needed by the disabled client and his family. These services should be closely coordinated with those that have been defined as "general supportive services" (especially 1.1 through 1.4).

2.1 Screening: The identification of an individual who is suspected of having a problem or possible problem related to developmental disabilities. (RT)

2.2 Diagnosis: Interdisciplinary investigation of an individual and his immediate environment to identify specific areas of delay and/or deviance and to specify causes where possible. (RT)

2.3 Evaluation: The systematic appraisal by a multi-discipline team to determine the extent to which the disability limits or can be expected to limit an individual's living activities; to determine how and to what extent the disabling condition(s) may be remediated or minimized; to determine the nature and scope of services to be provided; to select service objectives; and to devise an individualized action plan for intervention. "Interdisciplinary" can include professionals from a variety of fields such as medicine, psychology, education, social work. (AAMD,MHD,HEW)

3.0 TREATMENT

The discrete services in this cluster involve primarily the health needs of afflicted persons. Whenever possible, these services should be provided by generic agencies and professionals who serve the entire population, relying on special services for developmentally disabled people only as a last resort.

3.1 Medical Services: The service of diagnosing, treating, curing, and preventing disease, relieving pain, and improving and preserving health. Services may be provided through in-patient, out-patient, or emergency hospitalization treatment. (RT)

3.2 Dental Services: Preventive and restorative treatment for the teeth including inspecting, cleaning, filling of cavaties, extraction of teeth beyond repair, replacement of missing teeth with artificial ones, orthodontia, and cosmetic surgery. (RT)

3.3 Speech Therapy: The provision of services which deal with the elimination and alleviation of speech defects or with the development and improvement of speaking intelligibility. (RT)

3.4 Physical Therapy: Therapeutic use of physical agents other than drugs (i.e., physical, chemical, and other properties of heat, light, water, electricity, massage, exercise, and radiation) to maintain or increase efficiency of neuro-musculo, skeletal, cardiovascular, and respiratory systems. (Taber)

3.5 Occupational Therapy: Therapeutic use of activities such as self-help skills, arts and crafts, and perceptual motor activities to encourage clients to become motivated toward achieving their own normalization. (Taber)

3.6 Psychotherapy: Intensive psychological or behavioral therapy aimed at alleviating severe emotional and/or behavioral disorders. (RT)

4.0 EDUCATIONAL SERVICES

The discrete services in this cluster refer to programs that are designed to enhance growth and development in the areas of motor, self-help, communication, social, academic, prevocational, vocational, and independent living skills. Most of these programs are provided in public or private community schools, or in institutions for developmentally disabled people. Integration with regular school programs should be accomplished whenever possible.

4.1 Pre-school Services: Facility-based or home-based programs for children age 0 to 6 years offering structured training in communication, motor, self-help, and social skills. (RT)

4.2 School Services for Mildly Handicapped: Programs which emphasize academic, social, and communicative skills at the primary and intermediate levels, and pre-vocational, vocational, and independent living skills at the secondary level. (RT)

4.3 School Services for the Moderately, Severely, and Profoundly Handicapped: Programs which emphasize motor, communication, self-help, social, and appropriate academic skills at the primary and intermediate levels, and appropriate pre-vocational, vocational, and independent living skills at the secondary level. (RT)

4.4 Adult Basic Education: Educational opportunities in any of the following areas for adults who did not achieve their maximum level of competency while eligible for public school: communication, social, academic, pre-vocational, vocational, and independent living skills. (RT)

4.5 Special School Services: Services which are provided in conjunction with other educational programs that respond to the specific needs related to physically handicapping conditions of individuals who are blind, deaf, epileptic, and/or non-ambulatory. (RT)

5.0 COUNSELING SERVICES

The discrete services in this cluster provide the client and/or his family with emotional support, information, and advice which they need in order to enhance their ability to make and implement important decisions which will affect their style of life.

5.1 General Counseling: Regularly scheduled goal-oriented intervention that is responsive to the decision-making needs of the impaired individual or his family. The primary focus of this intervention is upon solving interpersonal problems such as disability acceptance, overanxiety, overprotection, and the ability to cope with daily demands which result from the client's disability. (RT)

5.2 Crisis Intervention: Counseling services which are available on an emergency basis, immediately responsive to family needs at a time of extreme stress. (RT)

5.3 Family Planning: Counseling services related to all aspects of pregnancy and child rearing, including knowledge of contraception and careful consideration over whether or not to parent children. (RT)

5.4 Genetic Counseling: Information and advice concerning the biological probabilities of giving birth to a developmentally disabled child. Karyotype analysis and interpretation of family geneologies are frequently included in this service. (RT)

6.0 FAMILY SUPPORT SERVICES

The discrete services in this cluster help families to cope more effectively with the presence of a developmentally disabled person in their home. These services include both the education and training of family members, as well as temporary or part-time respite care which is designed to relieve family members from the continuous burden of providing special care. The primary objective of all the family support services is to prevent institutionalization of the disabled person.

6.1 Family Education: Opportunities for the family to increase its knowledge and understanding of mental retardation and other developmental disabilities, and of the impact of these disabilities upon the family unit. (JCAH[1])

6.2 Family Training: A program of training for family members which provides them with the skills needed to assist the impaired person in the family by augmenting the services provided outside of the home with a program of structured activities inside the home. In essence, family members are trained to become their own service providers. (RT)

6.3 In-home Sitter Services: Services provided for the care of an individual in his home involving temporary seperation from his family for short periods of time on a regular or intermittent basis for the purpose of relieving the family of his care. (AAMD)

6.4 Out-of-home Sitter Services: Services provided for the care of an individual away from his home involving temporary separation from his family for short specified periods of time on a regular or intermittent basis for the purpose of relieving the family of his care. (AAMD)

6.5 Out-of-home Respite Care: Services provided for short-term residential care involving temporary separation of an individual from his family for specified periods of time on a regular or intermittent basis. (AAMD)

6.6 Homemaking: Chore and/or personal care services which must be provided to a developmentally disabled individual or his family to enable him to remain in his own home. These services may include, but are not necessarily limited to housecleaning, laundry, meal planning and preparation, feeding, bathing, shaving, dressing, etc. Services may or may not include training. This service may be provided by a certified agency such as Homemaker-Home Health Aide Services, Inc. (RT)

7.0 LIVING ARRANGEMENTS

The discrete services in this cluster provide a wide range of living arrangements for developmentally disabled persons. The various alternatives represent a continuum, one end of which provides an opportunity for nearly independent living, while the other end provides a living environment in which the impaired person's activities are almost entirely managed by other people.

7.1 Board and Room Living: A living situation for those individuals who can maintain or remain in an essentially unsupervised living situation. Participation in a community resource such as an Activity Center may be needed to sustain this level of independence. (RT)

7.2 Group Home Care: A closely supervised living situation in a facility serving not less than six clients. Since the goal of this program is semi-independent living, training must also be provided or made available to residents in the following areas: self-help skills, independent living skills, social behaviors, communication, education, vocational training and adjustment, recreation, and community orientation. (RT)

7.3 Foster Care: A family home which is willing to accept not more than five persons needing supervision within the context of a program of supporting services. The program of supplemental services for each resident can be provided on contract over and above the regular room and board rate. (RT)

7.4 Sheltered Care: A facility which provides residential care on a long-term basis for highly dependent persons without severe medical problems. The program of services should include stimulation of abilities and comprehensive recreational activities. (RT)

7.5 Nursing Home Care: A facility of six bed capacity or more which is intended for the residential care, treatment, and training of dependent persons. The facility is geared to serving the needs of persons with severe physical handicaps or medical problems on a relatively long-term basis. The program of services should provide special medical attention, stimulation of abilities, and comprehensive recreational opportunities based on the general needs of the residents. (RT)

7.6 Institutional Care: A self-contained facility, usually large in size, which provides residential care, medical treatment, and training for developmentally disabled people. (RT)

8.0 VOCATIONAL SERVICES

The discrete services in this cluster assist an impaired person in finding employment or other meaningful adult occupation. Economic self-sufficiency, whenever possible, is a major goal of these services. Achievement of the maximum occupational satisfaction that is possible for the impaired person, with or without remuneration, is also a major goal of these services.

8.1 Evaluation: A systematic appraisal of an individual's employability for the purpose of appropriate occupational placement or for devising an individualized program of training. Evaluation determines expected limitations upon an individual's vocational potential, and the extent to which these limitations can presumably be removed, corrected, or minimized by specific intervention services. (AAMD,HEW)

8.2 Training: An individualized program of action designed to increase a person's employability by removing, correcting, or minimizing problems which can be expected to limit the individual's work activities. The program may include prevocational and occupational skills training as well as work adjustment training. (RT)

8.3 Placement: Services which assist an individual in finding employment that is consistent with his capabilities and interests; placement services follow individual evaluation and, where needed, training programs. (RT)

8.4 Sheltered Employment: A structured program of activities involving: (1) short-term remunerative employment designed to affect placement in the competitive labor market, or (2) extended, long-term remunerative work in a protective environment. (RT)

8.5 Activity Center Program: An organized program which provides dignified and meaningful work, social, and recreational activities on a daily basis for adults who are not yet ready to engage in competitive or sheltered employment. (MHD)

8.6 Other Employment Services: Employers who will employ developmentally disabled persons on an individual or collective basis who require a minimum of supervision. Employment may be secured by the individual, or an agency other than the Division of Vocational Rehabilitation may make the placement. (MHD)

9.0 RECREATIONAL SERVICES

The discrete services in this cluster refer both to the therapeutic use of recreation and to the use of recreation for filling leisure time. In the latter sense, recreational activities can be planned or spontaneous, organized or unorganized, carried on alone or with others. This variability in function should be retained in recreational services.

9.1 Therapeutic Recreation: Purposeful intervention through recreational activities to modify, ameliorate, or reinforce specific physical, emotional, or social behaviors. (JCAH[2])

9.2 Leisure Time Recreation: The provision of ongoing programs and activities for the recreational use of leisure time. The choices of recreational activities should be of sufficient variety to permit individualized selection based on mental, physical, and emotional capacities, as well as urges of the moment. The various activities should provide outlets for physical interests (e.g., athletics), communicative interests (e.g., group discussions, writing), information interests (e.g., study group), creative and aesthetic interests (e.g., hobbies), and social interests (e.g., parties). Programs may include the teaching of skills related to the recreational activity selected. Use of generic recreational services should be used whenever possible. (CLS)

10.0 TRANSPORTATION

Public or private programs which enable handicapped people to travel around the communities in which they live and work. Whenever possible, these services should be delivered as modifications of existing transportation systems within the general population. (RT)

11.0 INDIRECT SERVICES

The discrete services in this cluster refer to activities and interventions with non-handicapped people which are undertaken on behalf of handicapped people.

11.1 Planning Coordination: Planning bodies (agencies, citizens groups and individuals) working together toward the development of a comprehensive service delivery system for developmentally disabled citizens. (RT)

11.2 Public Education: Dissemination of information to the general public, including educators, legislators, employers, physicians, service agencies and parents, concerning needs and rights of the developmentally disabled population. (RT)

11.3 Primary Prevention: The elimination or mitigation of those factors in life which frequently result in a higher incidence of mental retardation or other developmental disabilities. (RT)

11.4 Basic Research: Scientific methodology related to the prevention of developmental disabilities or community adjustment of developmentally disabled people, and the design and implementation of research relating to these questions. (RT)

11.5 Manpower Development: An integrated program of recruitment, pre-service training, and in-service training aimed at assuring the availability of an adequate present and future supply of qualified personnel to provide services to developmentally disabled people. (JCAH^1)

11.6 Data Management: The systematic collection, integration, and dissemination of information about the quantity, quality, and effectiveness of services for developmentally disabled people in order to enhance the procedures of planning, implementing, and evaluating the impact of these services. (RT)

11.7 Funding: Identification of local, state and federal funds specifically designated to research, programs, and services for the developmentally disabled population. (RT)

11.8 Elimination of Architectural Barriers: Efforts directed toward making all facilities accessible to the physically handicapped. (RT)

APPENDIX B

REPORTS AND RECOMMENDATIONS

Reports and recommended objectives were prepared for eight of the ten service areas defined in Section Two. Approximately 50 percent of the discrete services are addressed in these reports. The criterion for selection was whether or not a service is mentioned or implied in the eleven priorities of Oregon's 1974 State Plan.

A standard format has been followed, whenever possible, in the presentation of each report. First, an overview of the service area is presented, including the definitions of each discrete service in the cluster. The perceived availability of each service is then presented, based on the opinions of service coordinators and directors of community mental health programs. Additional information is presented next on those services within the clusters that are mentioned in the priorities of the 1974 State Plan. Data on the quantity and quality of each service are presented to the extent that information was available from the relevant state agencies. The final section of each report included the five kinds of recommendations: agency objectives, legislative objectives, short-term funding objectives, study objectives, and data-base objectives. Only the recommendations related to the first service report are included in this paper as an example of task force work.

1.0 GENERAL SUPPORTIVE SERVICES

The discrete services in this cluster provide the client and his family with support and assistance in finding and securing the various services that they need throughout their lives. Ideally, services 1.1 through 1.4 will be provided by a single agency in order to insure continuity of services to clients with a minimum of confusion.

Since developmentally disabled people must face problems which are themselves developmental, a service delivery system is required which is not only comprehensive in scope but also extend throughout the lifespan of afflicted individuals. Since most generic services are not this broad in scope, an additional cluster of services is needed by many developmentally disabled people which provides a fixed point for referral and helps to arrange for the continuity of services over the years. Seven such supportive services have been identified and defined at this time:

Casefinding: The process of systematically reaching into the community for the purposes of identifying persons in need of services; alerting persons and their families to the availability of services; and assisting persons to enter the service delivery system.

Information and Referral: The development and use of a resource catalog and retrieval system which can supply information about, and referral to, appropriate community resources. This information must be made available to any individuals who request help and whose needs can properly be met in this way.

Service Coordination: The process by which responsibility is established for implementation of the client's individual program plan at a given point in time. This process includes providing support to the client, procuring direct services, coordinating the services of different agencies, and monitoring the progress of the client.

Follow Along: The establishment and maintenance of regular communication on a life-long basis with clients and their families, as they desire, for the purpose of assuring that changes in their needs for service are recognized and appropriately met.

Protective Services: A system of professional services that monitors programs, and that assists disabled persons in securing their general and specific rights. Assistance is rendered by providing advice and guidance and, if necessary, by actively intervening in social and legal processes to safeguard the rights of the developmentally disabled by assuring that they receive appropriate services and by preventing their abuse.

Personal Advocacy: The provision of a competent citizen to assist and befriend an impaired person in coping with his problems; providing help and affection in a one-to-one relationship. One desired outcome of this service is to teach the impaired person, whenever possible, to become his own advocate.

Guardianship Services: The determination of whether or not an impaired individual requires personal or property guardianship, followed by assistance in the procurement of guardianship when appropriate.

Four of these services--casefinding, information and referral, service coordination, and follow-along--are provided in Oregon under the auspices of the Mental Health Division's program of service coordinators. The expansion and improvement of this program emerged as the first priority in Oregon's 1974 Developmental Disabilities State Plan. Since the definitions of services in this area have only recently been formulated, the organization of this report does not strictly follow along the lines of the defined services. Instead, the job description of the service coordinators has been used to structure an evaluation of this priority.

The job description includes five parts:

1. Identify and catalogue resources;
2. Identify and register people and their service needs;
3. Match dd people with appropriate services;
4. Determine unmet needs in the community and;
5. Facilitate development of needed resources and services.

This report will describe the efforts that are being made by the service coordinators to fulfill each of the above demands, the responsibilities that are implied by each job requirement, and the problems that are now becoming apparent to the service coordinators.

Identify and Catalogue Resources

During the first months on the job, the Service Coordinators spent the majority of their time contacting agencies and facilities that were serving the developmentally disabled population in their community to find out what services were available. They each made up a catalogue with information about the service providers. In some counties this information was then made available to the public on a limited scale. In other counties, because of printing expenses and lack of clerical help, the notebook was only used as a reference source for the service coordinator. With appropriate staff, time, and monies available, the catalogue could have become part of a resource information and data documentation service.

Feedback from the service coordinators indicated that because of the shortage of clerical help, the time spent in compiling the information and preparing it for publication was much greater than they had expected. So much so, in fact, that some of the service coordinators felt that the information was outdated by the time they had it all compiled. In addition, many service coordinators resented this task as one which took too much time away from direct service to clients.

Identify and Register People and Their Service Needs

The service coordinators who live in rural counties spend from 15-25 percent of their time visiting clients in their homes while trying to identify what services are needed. In the metropolitan areas, the service coordinators publicize that they are available, and depend on other agencies to do the outreach.

The service coordinators spend time in TMR and EMR classrooms, nursing homes, activity centers, sheltered workshops, and other facilities which serve the developmentally disabled. They have all established some sort of a filing system for identification and description of their clients. Although the filing systems vary from county to county, they all contain the names of every developmentally disabled person that has been directly identified to them as a potential or current user of services. The registries also include persons who have been referred to the service coordinators from institutions because they are being placed in the community, or legally discharged.

The service coordinators are expected to actively seek out persons in need of services (case finding), facilitate entrance into the service delivery system (entry), screen persons expected of having a developmental disability, and help provide a diagnosis and evaluation.

The service coordinators need to shorten the amount of time spent in the office working on their filing systems, and other documentations of need. Those who are located in Mental Health Clinics all stated that they needed at least a half-time secretary to facilitate the development of a more systematic form of keeping data. It is difficult to find the time to organize an ongoing outreach program for outlying areas, because of the demands of current clients, data documentation, and need to advocate for new services.

Several of the service coordinators stated that they felt it was unrealistic to expect that one person could identify every developmentally disabled individual in a whole county. Clients, and other service providing agencies, expect the service coordinators to do direct service tasks; placement into group homes, institutions, foster homes; counseling; family training; etc.

If the service coordinators were expected only to identify and register developmentally disabled persons and their service needs, this alone could be a full time job.

Match Developmentally Disabled Persons With Appropriate Services

By working with agencies and facilities which serve the developmentally disabled population, the service coordinators keep in constant contact with services that are available to their clients. After screening potential needers of services, and possibly working with staff from other agencies, they are able to make recommendations regarding which service would be appropriate for a particular client. In three counties with high population density, case development specialists have been hired to assist service coordinators in this component of their job.

In evaluating the extent of contact the service coordinators have with their clients, data were collected on each client with whom they worked during 1973. A client data sheet, which included a five point scale showing degree of contact, was filled out for each client. The first category was a third party contact, in which the service coordinator never actually saw the client, but gave information to that client's representative about a particular service. The second category was a phone contact with the client or a member of his family. The third was an office visit in which the client and service coordinator met together to establish a need. The fourth was a home visit in which the service coordinator saw the client in his natural environment. The fifth, and greatest degree of contact involved a staffing, in which the service coordinator met with staff from other agencies who were currently serving the client, and the client and his family to help form an individual program plan.

The following table represents the degree of contact which the service coordinators had with their clients. The seven counties in which the data were collected are listed on the left. No contact data was collected in Marion because it was the first county surveyed and this information was not asked for at that time.

It is obvious that the types of contact utilized for matching clients to services varies greatly among the service coordinators. The amount of time available for direct client contact seems to be the critical determinant in this area.

TABLE 1

DISTRIBUTION OF SERVICE COORDINATOR/CLIENT CONTACT

	Degree of Contact*				
	1	2	3	4	5
Coos	15%	27%	28%	47%	6%
Linn	3%	2%	26%	47%	22%
Lane	50%	12%	3%	22%	13%
Lincoln/Benton	2%	5%	5%	38%	50%
Clackamas	8%	18%	9%	63%	2%
Umatilla/Morrow	3%	1%	1%	60%	35%
Klamath/Lake	35%	5%	1%	42%	17%
Marion	--no data available--				

* 1 = Third Party
2 = Phone contact with client
3 = Office visit
4 = Home visit
5 = Interagency staffing

Determine Unmet Needs in Community

There is no structured process by which any of the service coordinators are collecting data to determine unmet needs in their counties. Each of the service coordinators receive many requests for needed services from their clients. If a request cannot be met by providing the client with what he needs, the service coordinator is made aware of a gap in services.

In some of the rural counties, where fewer services are available, the service coordinators feel that they can keep in close contact with what is offered and what is needed. In some of the metropolitan counties, one of the most time-consuming aspects of the job is to keep in touch with other agencies to find out what services are being provided and where the gaps are.

It is very difficult for the service coordinators to keep all the data that is necessary to document need in their counties. They each have a comprehensive idea of what services should be provided for their clients and what the high priority needs are in their counties, but they do not yet have the capacity to document these needs with hard data.

Facilitate Development of Needed Resources and Services

The service coordinators spend an average of 25 percent of their time working with local and state agencies and service providers to coordinate and facilitate the development of needed services. They attend meetings for local committees, state councils, city councils, service agencies, and service providers (group homes, etc.), in order to keep current with what services are needed in their counties. They also use these meetings to further educate the people in the community about programs and services which are needed by the developmentally disabled population.

In many counties, the service coordinators are working with some of the people in the community on writing proposals to get funding for new programs. This work takes a lot of time and energy, and there is no promise of funds.

Facilitating the development of new programs is an ongoing, time consuming task. The service coordinators are torn between actual direct contact with clients, and working only with agencies and community groups. Feedback from many of them suggested that there are two jobs listed under one job description. All of the service coordinators work many fifty hour weeks because of early morning or late evening meetings, traveling, client crises, or other demands.

Summary

The expectation that service coordinators can completely and successfully fulfill each of the five parts of the job description with little or no supporting staff is unrealistic. The dedication and hard work of the service coordinators has proven to be very valuable in offering more and better services to developmentally disabled clients. It has also revealed how much more can and needs to be done.

GENERAL SUPPORT SERVICES
AGENCY OBJECTIVES

Objective: The Mental Health Division should fund service coordinators in each Community Mental Health Program by 1977.

Rationale: Sixteen service coordinators are currently serving clients in twenty counties. The program has been implementing the following tasks for three years: registering developmentally disabled clients who are in need of services, documenting services that are available in the county served, matching clients with services, determining unmet client needs, and helping to develop new services. We prefer that these services be available in all communities.

GENERAL SUPPORT SERVICES

Objective: The Mental Health Division should develop a statement of minimum qualification for service coordinators this year. Funding of service coordinator positions within Community Mental Health programs should be contingent upon compliance with these minimum qualifications.

Rationale: During the initial implementation of the service coordination program, minimum qualifications for service coordinators were not described. Individuals have been hired on a subjective basis without uniformity across the total program. There have been no specific guidelines regarding the types of education and experiences that are relevant to the position. We prefer that there be a statement of minimum qualifications which would be applied throughout the state.

GENERAL SUPPORT SERVICES

Objective: This year the Mental Health Division should develop a public information program which would publicize the services that are available through the service coordinators. The program should reach individuals as well as public and private agencies.

Rationale: It appears that in the twenty counties where service coordinators are operating, a small proportion of the developmentally disabled population is aware of the program. Perhaps as little as 30 percent of the eligible population has actually made use of the service. Repeated reports from service coordinators indicate that some agencies in those counties are also unaware of the presence of service coordinators. Coordination cannot be effective under these circumstances. We prefer that the existence of service coordinators and the assistance they can offer be well publicized. The publicity should be directed toward potential clients as well as all the public and private agencies that relate directly or indirectly to the developmentally disabled population.

GENERAL SUPPORT SERVICES

Objective: Developmental Disabilities Coalition (Oregon Association for Retarded Citizens, United Cerebral Palsy, Epilepsy League) should retain a lawyer this year to assist in the implementation of direct legal services to developmentally disabled clients, utilizing and educating the existing legal aid programs statewide by 1976.

Rationale: The personal and legal rights of developmentally disabled clients have received the attention of legislators and consumer groups. Those rights have been delineated. At the present time, however, there is no accessible, effective legal advocacy program knowledgeable about the needs of developmentally disabled individuals which offers direct services to developmentally disabled clients in regards to preserving their rights. We prefer that such a program be implemented by the consumer groups.

GENERAL SUPPORT SERVICES

Objective: Mental Health Division should accept budgetary responsibility for secretarial assistance assigned specifically to each service coordinator.

Rationale: Service coordinators must provide many services to many clients. Without exception, they lack adequate clerical assistance. As the roles have developed and more clients are being served, administrative responsibilities have become increasingly burdensome. We strongly prefer that assistance be made available to all service coordinators through the assignment of sufficient secretarial help. The purposes of this recommendation are to relieve the coordinators of clerical office work; to improve the maintenance of related records; and to free service coordinators for continuing and expanding their provision of services to clients.

GENERAL SUPPORT SERVICES

Objective: Mental Health Division should develop and implement an in-service education program for directors of Community Mental Health Programs regarding the needs of developmentally disabled people in order to assist them in planning for that population.

Rationale: Within the last year, directors of Community Mental Health Programs have been given the responsibility of planning for the delivery of services to developmentally disabled people. Formerly, their primary concern was with the mentally and emotionally disturbed. The needs of these populations differ in many ways. We recommend that those who are responsible for planning for developmentally disabled people be included in a program which will increase their awareness of the characteristics and needs of developmentally disabled individuals and the ways in which services can most usefully be provided to them.

GENERAL SUPPORT SERVICES
LEGISLATIVE OBJECTIVES

No legislative objectives were generated in this service area.

GENERAL SUPPORT SERVICES
SHORT-TERM FUNDING OBJECTIVES

Objective: Funds should be allocated for a training program for developmentally disabled people and/or their families on self advocacy (self representation) as it applies to membership on boards and committees, or direct contact with agencies and the community as a whole.

Rationale: Developmentally disabled people should have a voice in decisions that are being made regarding their individual programs and the delivery of services as a whole. Traditionally, third party advocates represent the interests of the developmentally disabled population. The goal of advocacy, however, is the development of each person's ability to represent his own interests. Currently there is no program that addresses this goal directly. We prefer that a program be developed which would train developmentally disabled people and/or their families in the skills and awarenesses they need to be their own advocates. This should include their participation in committees and consumer groups as well as their individual relationships with serving agencies and the community.

GENERAL SUPPORT SERVICES

Objective: DDSA funds should be allocated to training for service coordinators. The training proposal should include a needs assessment component in order to ascertain the most critical present needs of service coordinators for in-service training.

Rationale: Three years of experience in the field of service coordination has allowed the Mental Health Division and the service coordinators to more clearly describe the potentials and problems of the program. At this time the service coordinators are in a position to benefit from a training program. We prefer that a training program be provided with specific objectives related to the job as it now is being implemented.

GENERAL SUPPORT SERVICES
STUDY OBJECTIVES

Objective: The relationship and roles of various agencies in regards to services coordination should be studied.

Rationale: Services coordination is provided by many agencies at this time. The proliferation of this activity may or may not be in the best interest of the clients. We prefer that the provision of services coordination by a variety of agencies be studied in terms of the impact on the client and the appropriateness of duplicating services and cost.

GENERAL SUPPORT SERVICES

Objective: A study should be conducted of local Community Mental Health Advisory Boards and/or local Developmental Disabilities Councils regarding the affiliations of members, and their planning efforts for developmentally disabled clients with respect to the scope and impact of their plans.

Rationale: Different agencies and committees which are responsible for planning at the local level construe their roles differently. In planning for developmentally disabled people they demonstrate varying degrees of concern for consumer involvement. They show different degrees of attention to the private sector of service delivery. Some types of planning focus primarily on state budgetary demands; other types attend more to community development. We would like to know how local planning is being done, who it tries to affect, to what extent it is responsive to the concerns of developmentally disabled people.

GENERAL SUPPORT SERVICES
DATA COLLECTION OBJECTIVES

Objective: Mental Health Division should continue the development and implement a uniform data collection system for monitoring services to developmentally disabled clients. The system should be implemented by the end of this fiscal year.

Rationale: Effective planning, budgeting, and monitoring the delivery of services require continuous feedback about the quantity, quality, and effectiveness of the services being provided to developmentally disabled clients. At the present time, the state has no uniform data collection system. We prefer that such a system be developed and implemented by the Mental Health Division.

2.0 IDENTIFICATION AND ASSESSMENT

The discrete services in this cluster are aimed at identifying people from the general population who might be developmentally disabled, following through with specific assessment procedures to pinpoint the nature of the disability, and developing recommendations for specific services that are needed by the disabled client and his family. These services should be closely coordinated with those that have been defined as "general supportive services."

Identification activities frequently provide the point of entry into the service system for developmentally disabled people. The activities should be sufficiently comprehensive to locate all afflicted people who might need services and guide them into the service delivery system.

Once an individual has been identified as having a problem or possible problem related to developmental disabilities, he should have ready access to an individual assessment in order to diagnose the problem accurately and develop an effective program plan.

The spectrum of services included under identification and assessment are:

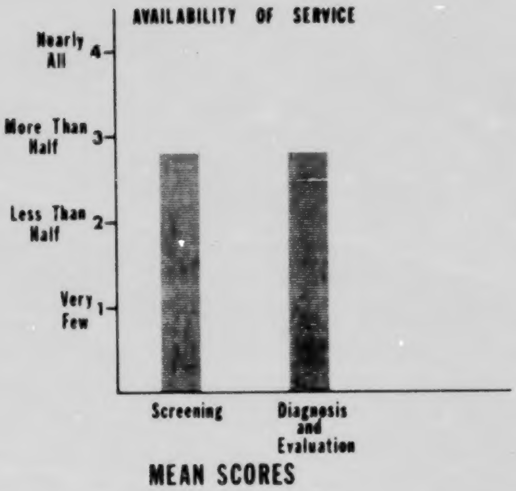
> Screening: The identification of an individual who is suspected of having a problem or possible problem related to developmental disabilities.
>
> Diagnosis: Interdisciplinary investigation of an individual and his immediate environment to identify specific areas of delay and/or deviance and to specify causes where possible.
>
> Evaluation: The systematic appraisal by a multi-discipline team to determine the extent to which the disability limits or can be expected to limit an individual's living activities; to determine how and to what extent the disabling condition(s) may be remediated or minimized; to determine the nature and scope of services to be provided; to select service objectives; and to devise an individualized action plan for intervention. "Interdisciplinary" can include professionals from a variety of fields such as medicine, psychology, education, social work.

In gathering data for this report, a questionnaire was sent to service coordinators and directors of Community Mental Health Programs asking them to assess, from their own experiences and perceptions, the extent to which services are available in their communities to the developmentally disabled clients who need them. Each direct service that has been defined was rated on the following scale:

1--available for very few who need
2--available for less than half who need
3--available for more than half who need
4--available for nearly all who need

The following graph (Fig. 1) shows the mean scores of the respondents for the three services included in this report. Diagnosis and evaluation were rated as a single service.

Figure 1



As the graph shows, the respondents believe that screening, diagnosis, and evaluation services are available to more than half of those who need them.

2.1 SCREENING

The Public Welfare Division of the State of Oregon has implemented a program of Early and Periodic Screening, Diagnosis and Treatment called MEDICHECK. The program is part of Title XIX benefits and covers eligible children under 21 years of age. MEDICHECK is intended to provide services to as large a number of children as possible with minimal duplication of services. Children who are eligible are those who are receiving protective services through Children's Services Division or financial assistance through Public Welfare Division.

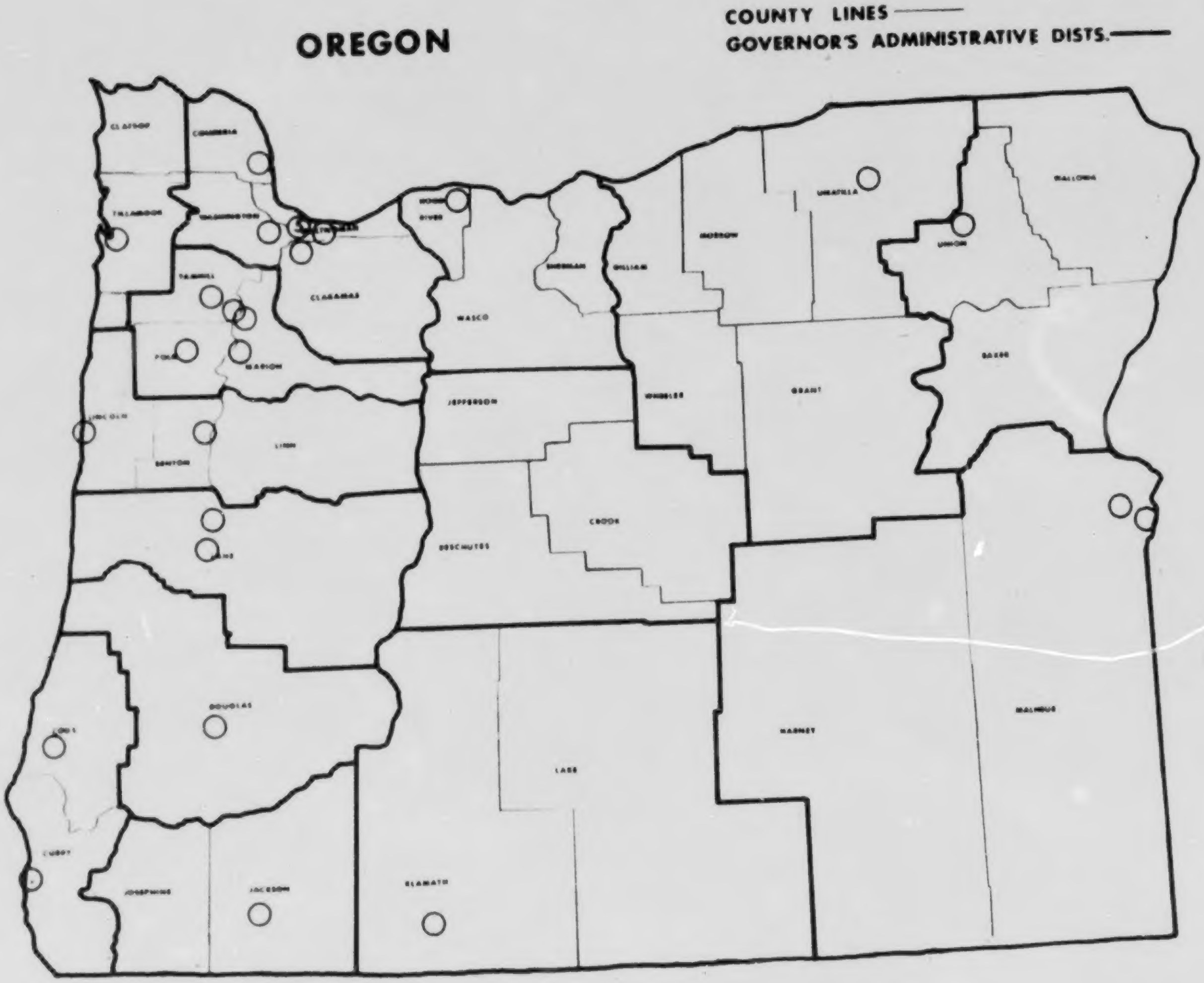
Facilities

As stated in Rules and Regulations for the MEDICHECK program, screening services may be provided by any physician or facility with staff licensed to practice medicine in the State of Oregon or specially trained nurses or para-medical personnel under a physician's supervision. The screening may be done by a private provider as part of the regular medical care of a family or individual, or a screening center such as Health Clinics, Well Baby Clinics, School Health Programs, Crippled Children's Services, Maternity and Infant Care projects, and neighborhood health centers.

As of January, 1974, the Medical Assistance Section of the Public Welfare Division had Medicheck Agreements (signed contractual agreements on file) with 28 screening centers operating 31 facilities. The following map shows the locations of these facilities:

Figure 2

Facilities Offering Medicheck Screening Services

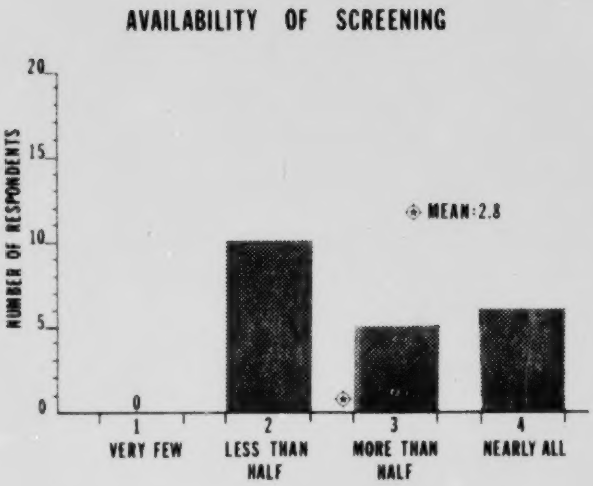

OREGON
COUNTY LINES
GOVERNOR'S ADMINISTRATIVE DISTS.
CLATSOP
COLUMBIA
TILLAMOOK
WASHINGTON
MULTNOMAH
HOOD RIVER
YAMHILL
CLACKAMAS
WASCO
SHERMAN
GILLIAM
MORROW
UMATILLA
UNION
WALLOWA
POLK
MARION
JEFFERSON
LINCOLN
BENTON
LINN
WHEELER
GRANT
BAKER
CROOK
DESCHUTES
LANE
DOUGLAS
COOS
CURRY
JOSEPHINE
JACKSON
KLAMATH
LAKE
HARNEY
MALHEUR

Clients

Direct client data are not available for screening services. The Public Welfare Division was not able to provide information regarding the number of clients with the disabilities of mental retardation, cerebral palsy, and/or epilepsy screened through its programs during fiscal year 1973.

The availability of screening services as perceived by the service coordinators and directors of Community Mental Health Programs is shown in the following graph.

Figure 3



The graph indicates that while many respondents believe that screening services are available for less than half of the people who need them, more of the respondents believe more than half or nearly all developmentally disabled clients have access to screening.

Standards

A document published by Public Welfare Division, "Guide for Early and Periodic Screening, Diagnosis and Treatment," delineates a Schedule of Screening Services. The schedule presents the services that are to be provided for each age group (2 months through 20 years). The screening is multi-purpose and will include health and developmental history (physical and mental); assessment of physical growth, development, and nutritional status; inspection for physical defects; and screening for other abnormalities, conditions, and infections. Payment through the MEDICHECK program requires an acknowledgement that the rules and regulations set forth in the guide have been followed. Beyond its use in the MEDICHECK program, the guide may be seen as a useful standard for all physicians and health programs.

Conditions for referral are included in the guide. If, during the screening process, a significant medical condition detrimental to the child's physical or mental health is discovered, the child may be referred to a medical practitioner qualified to provide definitive diagnosis for a prescriptive course of treatment. A special notification form has been developed to assist in the referral process. It is a four-part form intended to notify all parties concerned that a referral has been made.

Statement of Progress

Medicheck is a departure in philosophy for the Public Welfare Division, in terms of its earlier medical program, as it embraces preventive medicine rather than the traditional posture of providing emergent care. It adds a new screening service that was not available last year.

It is not possible to make a comparative statement about the number of clients served this year and last; client data were not available in the baseline or follow-up reports.

2.2 & 2.3 DIAGNOSIS AND EVALUATION

Diagnostic services are available to eligible individuals through the MEDICHECK program and are subject to the rule, regulations, and procedures set forth in the guide as appropriate. Under the program, diagnosis and evaluation may be provided through a health center or private practitioner qualified to make the diagnosis and evaluative assessment. The vehicle for referral allows for client movement into a full diagnostic center such as those maintained by Crippled Children's Division; The Center for Neurologically Impaired Children; and Mental Health Division.

Facilities

Crippled Children's Division currently has four sites for diagnosis and evaluation clinics. These are in Portland, Eugene Medford and Corvallis. The Division also provides for specific situations where children may be evaluated in physicians' offices throughout the state. Public health nurses provide an additional facet of care in enabling the division to reach out into other communities.

The Center for Neurologically Impaired Children operates out of Good Samaritan Hospital in Portland.

The Diagnosis and Evaluation Section of the Mental Health Division provides services to any person with known or suspected mental retardation. Evaluations normally are conducted at Fairview State Hospital and Training Center, but evaluation teams may make visitations to communities.

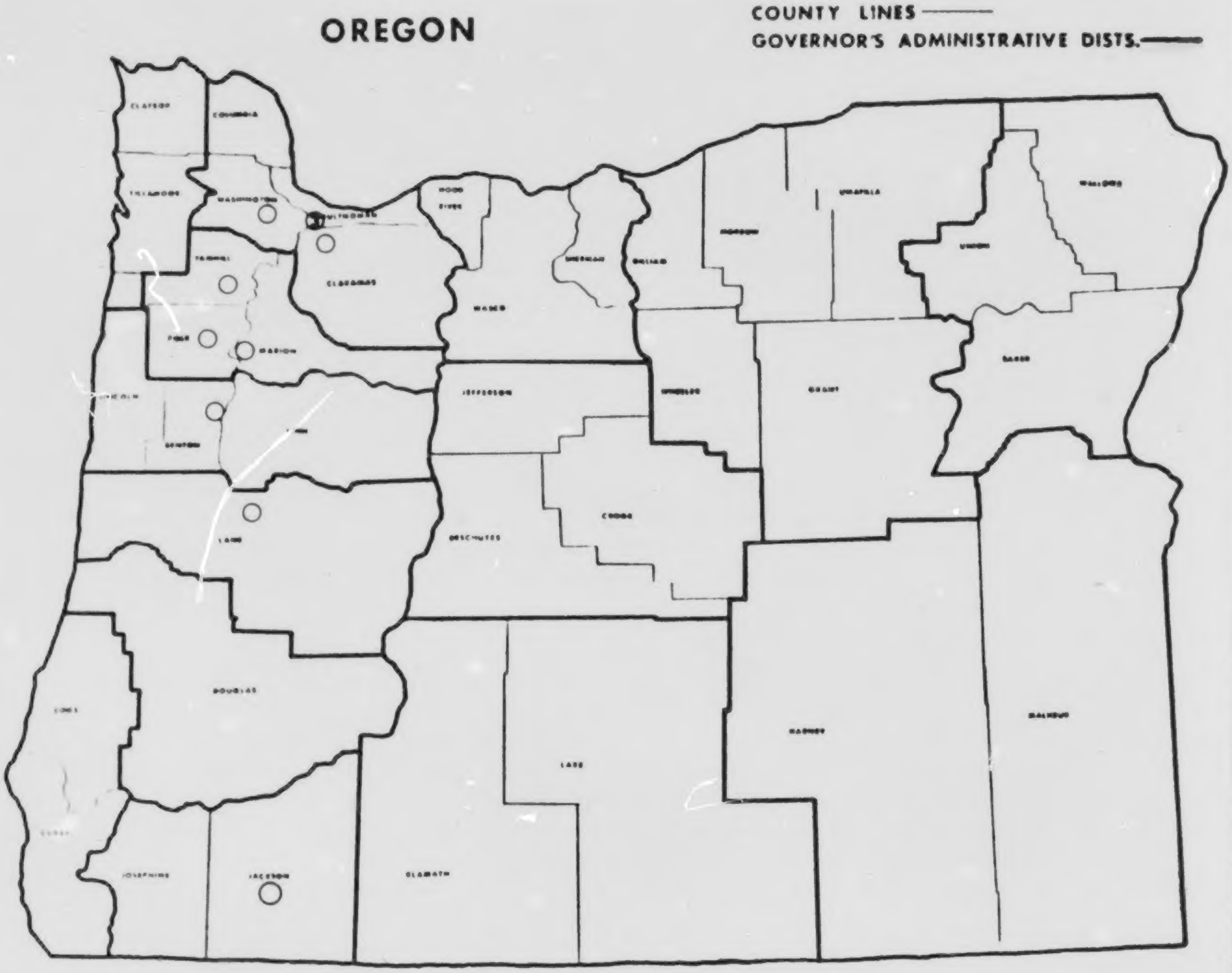
The Maternal and Child Health Section of the Health Division supports four Child Development Clinics located in Washington, Clackamas, Yamhill, and Polk Counties.

The neurology center at the University of Oregon Medical School conducts evaluation for epileptic patients. Additionally, patients seen for other medical problems may receive evaluative services related to concomitant problems of mental retardation or cerebral palsy.

The map on the following page shows the locations of the diagnostic and evaluation centers referred to above.

Figure 4

LOCATION OF FACILITIES PROVIDING DIAGNOSIS AND EVALUATION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JEFFERSON
WHEELER
GRANT
BAKER
CROOK
DESCHUTES
DOUGLAS
COOS
CURRY
JOSEPHINE
JACKSON
KLAMATH
LAKE
HARNEY
MALHEUR

Clients

Information regarding the actual number of clients served through the Crippled Children's Division from July 1, 1973 to December 31, 1973, was provided by that agency. Table 1 shows the distribution of clients served by Mental Health Region and the relationship of that figure to the total served and the total population of region and state.

Table 1

CLIENTS RECEIVING D & E THROUGH CCD, JULY 1, 1973 TO DEC. 31, 1973

	Number Served	% of Total Served	Population in Region	% of Total Population
Region 1	450	60.4	909,465	43.5
Region 2	262	35.2	1,015,037	48.5
Region 3	33	4.4	166,875	8.0
TOTAL STATE	745	100%	2,091,377	100%

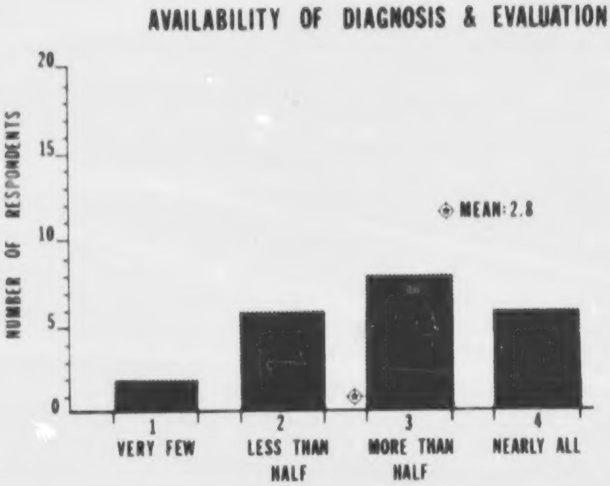
The table indicates that relative to population distribution, Mental Health Region 1 is receiving a disproportionately large share of the diagnosis and evaluation services available through CCD while regions 2 and 3 both receive disproportionately less.

Additional information on the clients served by CCD is available in the appendix.

Client information on diagnosis and evaluation was not provided by Health Division, Center for Neurologically Impaired Children, or Public Welfare Division.

The availability of diagnosis and evaluation services as perceived by the service coordinators and directors of Community Mental Health Programs is shown in the following graph.

Figure 5



As indicated in the graph, the most frequent response concerning the availability of diagnosis and evaluation was "available for more than half of those who need it."

Standards

There are no published standards for diagnosis and evaluation of developmentally disabled people seen through Crippled Children's Division at this time. It is known, however, that clients in this program are seen by a variety of disciplines; primarily pediatricians, social workers, psychologists, speech pathologists (as a minimum). Additionally, all the children with cerebral palsy are seen by neurologists, orthopedists and physical and occupational therapists. As a standard, it is required that the individuals who function in the clinics be licensed by the state in their respective disciplines and that the physician who functions in the program be certified in his respective specialty.

Guidelines or policies regarding standards for diagnosis and evaluation were not available from the other agencies which provide this service.

Statement of Progress

Comparative analysis of FY 73 data with the baseline data is difficult to make on two counts: (1) baseline data include, for the most part, estimates of number served during calendar year 1972; (2) data are incomplete for FY 73 in regards to agencies previously mentioned. It appears that Crippled Children's Division served about the same number of people in FY 73 as in six months of calendar year 1972 (1500 estimated as having received services in 1972 and 744 actually received services from July 1 to December 31, 1973).

Reports recently presented to the State Developmental Disabilities Council by Dr. Rhesa Penn concerning the four Child Development Clinics indicated that there may be a cutback in that program.

APPENDIX

Table 2

CLIENTS SERVED BY CCD FROM JULY 1, 1973 TO DEC. 31, 1973 BY AGE

	MR	CP	E	M.H.	TOTAL
0-2 years	9	7	3	13	32
3-6 years	96	65	6	95	262
7-21 years	142	133	8	189	472

Table 3

CLIENTS SERVED BY CCD FROM JULY 1, 1973 TO DEC. 31, 1973 BY REGION

	MR		CP		E		MH		% of State's population in region
	N	%	N	%	N	%	N	%	
Region 1	145	60.7	120	59.4	8	53.3	177	61.5	43.5
Region 2	85	35.6	73	36.1	7	46.7	97	33.7	48.5
Region 3	9	3.8	9	4.5			14	4.9	8.0
Total	239	100.0	202	100.0	15	100.0	288	100.0	100.0

4.0 EDUCATIONAL SERVICES

The discrete services in this cluster refer to programs that are designed to enhance growth and development in the areas of motor, self-help, communication, social, academic, prevocational, vocational, and independent living skills. Most of these programs are provided in public or private community schools, or in institutions for developmentally disabled people. Integration with regular school programs should be accomplished whenever possible.

4.0 EDUCATIONAL PROGRAMS

While each person possesses the potential for growth and development, specific opportunities for growth and development must be provided if the potential is to be realized. Educational programs, as they are part of a comprehensive system of services for developmentally disabled people, attend to the individual's developmental needs. The programs begin in infancy and may extend into adulthood. As it is appropriate to the individual's developmental level, each of the following areas should become part of the educational program plan:

> Motor development: the development of behaviors that primarily involve muscular, neuromuscular, or physical skills, and that involve varying degrees of physical dexterity.
>
> Communication development: the development of communication skills, verbal and non-verbal, as a method of maintaining contact with, and responding to, the social environment.
>
> Affective development: the development of feelings, emotions, and behaviors that relate to, arise from, or influence interests, attitudes, emotions, and values.
>
> Cognitive development: the development of those processes and abilities involved in perceiving, recognizing, remembering, conceiving, judging, reasoning, thinking and knowing.
>
> Social development: the development of skills and behaviors conducive to appropriate and constructive interactions in areas such as one-to-one communication, group participation, and social adjustment.
>
> Self-help skills development: the development of skills which allow the individual to assume increasing responsibility for independent personal care (toileting, eating, dressing, grooming).
>
> Independent living skills development: the development of skills that are conducive to successful independent or semi-independent living, relating to such tasks as cooking, housecleaning, care of clothes, budgeting, shopping, reading labels and directions.
>
> Vocational development: a systematic development of skills related to work adjustment (work habits and attitudes)

along with job related skills directed toward increasing mobility in the job market.

The objectives of education and training programs should be directed to maximizing the client's development in each of the developmental domains. Tools for evaluating client growth in each domain should be part of the program. The tools should be designed in such a way as to give the teacher/trainer accountability for client change.

The spectrum of educational services includes the following:

Preschool Services: Facility-based or homebased programs for children age 0 to 6 years offering structured training in communication, motor, self-help, and social skills.

School Services for Mildly Handicapped: Programs which emphasize academic, social, and communicative skills at the primary and intermediate levels, and pre-vocational, vocational, and independent living skills at the secondary level.

School Services for the Moderately, Severely, and Profoundly Handicapped: Programs which emphasize motor, communication, self-help, social, and appropriate academic skills at the primary and intermediate levels, and appropriate pre-vocational, vocational, and independent living skills at the secondary level.

Adult Basic Education: Educational opportunities in any of the following areas for adults who did not achieve their maximum level of competency while eligible for public school: communication, social, academic, pre-vocational, vocational, and independent living skills.

Special School Services: Services which are provided in conjunction with other educational programs that respond to the specific needs related to physically handicapping conditions of individuals who are blind, deaf, epileptic, and/or non-ambulatory.

In gathering data for this report, a questionnaire was sent to service coordinators and director of Community Mental Health Programs asking them to assess, from their own experiences and perceptions, the extent to which services are available in their communities to developmentally disabled clients who need them. Each direct service that has been defined was rated on the following scale:

1 -- available for very few who need it
2 -- available for less than half who need it
3 -- available for more than half who need it
4 -- available for nearly all who need it.

The following graph (Figure 1) shows the mean scores of the respondents for the two services included in this cluster that are covered in this report.

Figure 1

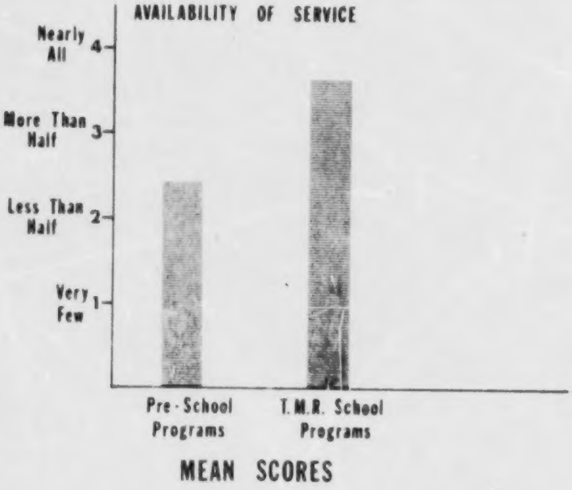


Figure 1 indicates that the respondents believe that preschool services for developmentally disabled children are available for less than half who need them and that TMR school programs are available for nearly all who need them.

4.1 PRESCHOOL SERVICES

Preschool services for severe developmentally disabled children are provided through the Mental Health Division of the State of Oregon. The programs are designed to provide: (1) children ages 0-6 years with individualized training programs to enhance their physical, intellectual, emotional, and social development; and (2) skill training to the parents of these children so they may become active partners with the school program to stimulate and train the child on an individual basis.

Programs developed for the delivery of preschool service include infant stimulation in the home, school setting (day) programs, and parent training. Parent training is provided throughout pre-school years and may be conducted in the school and home settings. Parent training augments the home-infant stimulation and the classroom day programs. The data on parent training programs are included in report 6.0, Family Support Services; therefore it will not be included in this report. This report will discuss home infant stimulation programs and classroom day programs.

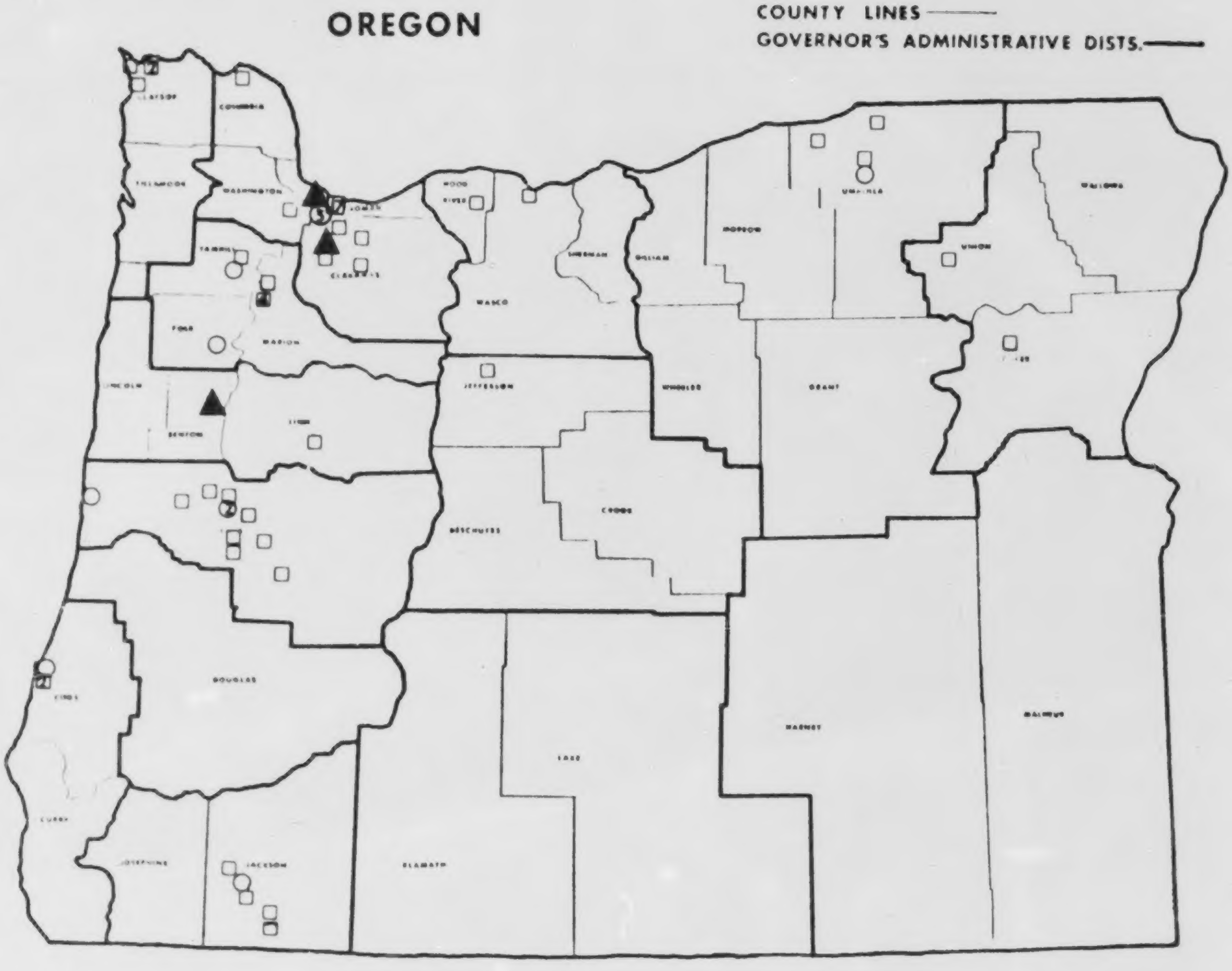
Facilities

Preschool programs for severely disabled children were operational for the 1973-74 school year in ten counties. There were fourteen sites offering classroom services through the Mental Health Division program; three counties also provided home instruction.

In addition to the programs administered through Mental Health Division for severely developmentally disabled children, some developmentally disabled children received preschool services through the Head Start Program. Eleven counties reported serving developmentally disabled children in Head Start classes. The following map (Figure 2) shows the locations of the Mental Health Division classroom program, home instruction programs, and the Head Start Programs serving developmentally disabled children.

Figure 2

LOCATIONS OF PRESCHOOL PROGRAMS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COOS
CURRY
JOSEPHINE
JACKSON
KLAMATH
LAKE
HARNEY
MALHEUR

▲ = Home instruction

○ = MHD Preschool Classroom Programs

□ = Head Start Classrooms

Clients

Information concerning the number of children receiving preschool educational services through the Mental Health Division is not available. Data from the Head Start Programs show that 50 developmentally disabled children were receiving services through their classrooms during the July 1 to December 31, 1973 period. (Not all programs provided data so the count is conservative.) The children served in the Head Start Program are between the ages of 3 and 6 years. Seventy six percent (76%) of the developmentally disabled children being served by those reporting are mentally retarded.

The availability of preschool services as perceived by the service coordinators and directors of Community Mental Health Programs is shown in the following graph.

Figure 3

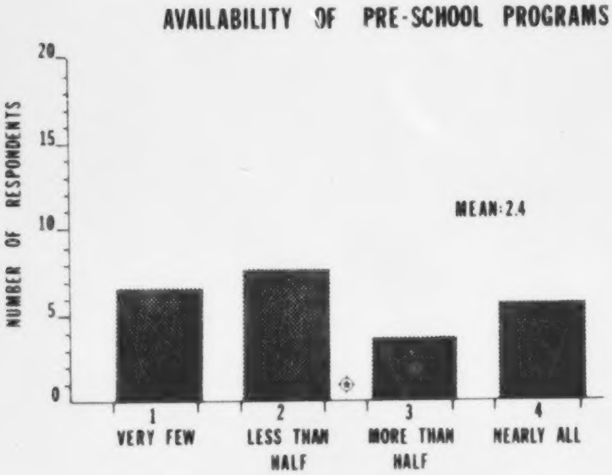


Figure 3 indicates that the most frequent response concerning the availability of preschool programs was "available for less than half."

Standards

Mental Health Division is in the process of developing standards for the preschool services under its jurisdiction. Information was not provided regarding the content of the standards in draft or the vehicle for enforcement of standards.

The Head Start office publishes a policy manual which includes performance standards for administering and carrying out the program. The policy manual delineates educational objectives, social service objectives, parent involvement objectives, health services objectives, mental health objectives, and nutrition objectives. Performance standards are described for each set of objectives. The Office of Child Development, HEW Region X, is responsible for enforcing the program standards. This is accomplished through periodic on-site evaluations by Region X teams and regular reports submitted by grantees. Compliance with the standards is a condition of funding. With regard to facilities and staffing patterns, the Head Start Programs must meet state day care certification requirements as established by Children's Services Division. Information was not provided about the number of Head Start programs currently meeting the program standards.

Statement of Progress

The delivery of educational services to preschool-age developmentally disabled children has improved during the six month period, July 1 to December 31, along three dimensions. While client figures are not available to document these conclusions, it is safe to assume that more developmentally disabled children were receiving subsidized preschool programs in Fiscal Year 73-74 than in Fiscal Year 72-73 because of two program changes. In July, 1973, Head Start classrooms were mandated to increase the services to handicapped children to 10 percent of the total children served. During the same period, Mental Health Division expanded its preschool services to severely disabled children by funding five new programs and expanding the number of children served in existing programs significantly.

In addition to increasing the total number of children served, there was improvement in the range of disabilities served. The expansion in the Head Start Program absorbed children who are mildly disabled and can be integrated into regular classrooms. The expansion of the Mental Health Division programs provided more room for moderately and severely disabled children.

The third dimension along which services improved relates to the development of standards for preschool programs for severely disabled children. While this task is not complete, considerable time and resources have been given to the project by Mental Health Division. The adoption of standards should occur during the next year and should lead to significant progress in the quality and effectiveness of preschool education.

4.3 SCHOOL PROGRAMS FOR MODERATELY, SEVERELY, AND PROFOUNDLY HANDICAPPED

The Mental Health Division currently contracts with local public school and private school agencies for the provision of educational services to the trainable mentally retarded (TMR) school age population as authorized by ORS 430.760-430.820. The programs are funded on an "excess costs" formula: School Districts provide their per capita cost and the Mental Health Division, with funds allocated by Enrolled House Bill 1217, pays the excess costs of the approved budget. Classroom programs usually are established when six students have been identified; however, classes have been started in several rural areas with fewer than six students. Children ages 4 through 21 years are eligible for these programs if they do not qualify for programs for the educable mentally retarded. There is no minimum IQ for eligibility.

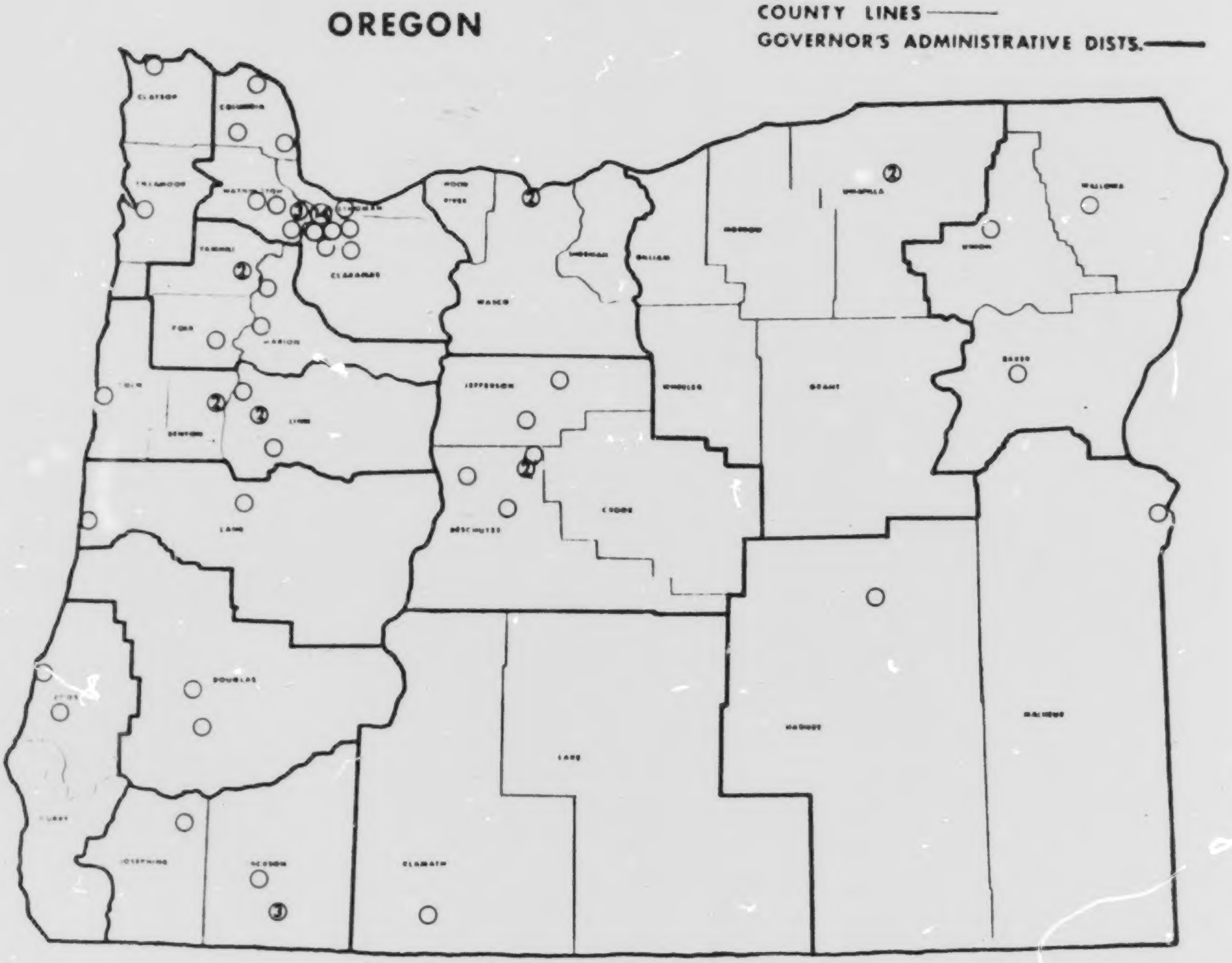
The purpose of the TMR educational programs is to maximize the normalization of each student by developing him to his fullest potential in communication, social, motor/physical, quantitative, practical and community living skills. In addition, an attempt is made to include him in as many activities as possible with "regular" school students.

Facilities

TMR students are being served in 119 classrooms in the state. Classrooms are generally located in regular public school buildings nearest the heaviest concentrations of eligible students. The Mental Health Division contracts with 33 local public school and two private school agencies in 27 counties to operate and supervise the services. The map on the following page shows the locations of TMR classrooms.

Figure 4

LOCATIONS OF TMR PROGRAMS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JOSEPHINE
CURRY
COOS
DOUGLAS

Clients

Information regarding the actual number of clients served through the TMR programs was provided by Mental Health Division for the school year period September through December 1973. Table 1 shows the distribution of clients served by region and the relationship of that figure to the total served and the total population of region and state. It appears that the distribution of TMR services is proportionally identical to the population distribution in the state.

Table 1

CLIENTS IN TMR PROGRAMS, FY 1973

	Number Served	% of Total Served	Population in Region	% of Total Population
Region 1	522	44.7	909,465	43.5
Region 2	546	46.8	1,015,037	48.5
Region 3	99	8.5	166,875	8.0
TOTAL STATE	1166	100.0%	2,091,377	100.0%

The availability of TMR services as perceived by the service coordinators and the directors of Community Mental Health Programs is shown in the following graph.

Figure 5

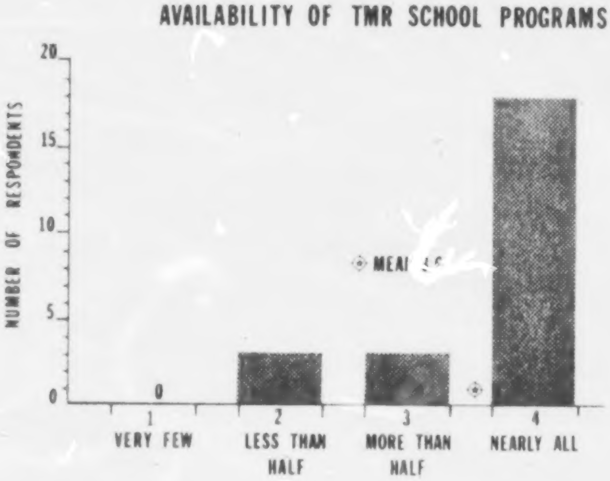


Figure 5 clearly indicates that most of the respondents believe that TMR services are available for nearly all who need them.

Standards

Oregon Mental Health Division has published standards for Classroom Services for Trainable Mentally Retarded under Administrative Rule 41.000. The rules are currently being revised. The standards, as they read now, describe eligibility criteria, administrative agreements, staffing standards, and facility standards. The standard for teacher/student ratio is one teacher for a maximum of ten students.

In addition to the rules described above, a basic core curriculum, the Student Progress Record and Curriculum Guide, has been developed by TMR teachers and the Mental Health Division, MR/DD Section. It is a behaviorally based curriculum, specifying a hierarchy of behaviors in successive approximation toward normalization. The Student Progress Record serves two basic purposes: (1) It serves as minimal required curriculum for all TMR classroom programs; and (2) it serves as an evaluation instrument to measure student progress in the required curriculum, assuring a minimal standard of program effectiveness.

Standards are enforced through individual child evaluations twice each year, annual on-site reviews, and annual contract negotiations. All facilities currently contracting with the Mental Health Division for delivery of TMR classroom services are in compliance with the standards.

Statement of Progress

It is not possible to make a comparative analysis between baseline and follow-up data as the baseline data did not provide the total number of TMR students receiving services.

4.2 SCHOOL SERVICES FOR MILDLY RETARDED

4.4 ADULT BASIC EDUCATION

4.5 SPECIAL SCHOOL SERVICES

Data were not collected on these educational services since they were not identified in the priorities of the 1974 State Plan.

5.0 COUNSELING SERVICES

The discrete services in this cluster provide the client and/or his family with emotional support, information, and advice which they need in order to enhance their ability to make and implement decisions. These services differ from psychotherapy in that temporary impairment in decision making ability is the reason for referral rather than severe emotional or behavioral disorders.

5.0 COUNSELING

In efforts to support an adaptive, communal, regulated way of life, society has developed many institutionalized ways of rendering help, assistance, or service to its individual members. Counseling, as a "helping" mechanism, is provided in non-institutionalized as well as institutionalized ways. Family members, friends, those who are part of an individual's "support group," often render counseling services of all types: general counseling, crisis counseling, life-span planning, family planning. The provision of these services has become institutionalized where it is believed that special skills are needed to respond to a particular type or degree of need.

Counseling services, as they are provided through a service delivery system, are generic (i.e., not oriented toward a single condition such as mental retardation, visual impairment, etc.) and frequently ancillary (i.e., subordinate to the primary service that an agency offers). In the latter sense, counseling may be provided in a variety of settings such as a group home, workshop, or classroom; or in conjunction with various primary services, such as evaluation, service coordination, or follow-along. While ancillary counseling services meet many of the needs of developmentally disabled people and their families, counseling should also be available as a discrete service for persons whose counseling needs require special expertise. Counseling services should offer the following types of assistance singly or in combination:

> General Counseling: Regularly scheduled goal-oriented intervention that is responsive to the decision making needs of the impaired individual or his family. The primary focus of this intervention is upon solving interpersonal problems such as disability acceptance, overanxiety, overprotection, and the inability to cope with daily demands which result from the client's disability.
>
> Crisis Intervention: Counseling services which are available on an emergency basis, immediately responsive to family needs at a time of extreme stress.
>
> Family Planning: Counseling services related to all aspects of pregnancy and child rearing, including knowledge of contraception and careful consideration over whether or not to parent children.
>
> Genetic Counseling: Information and advice concerning the biological probabilities of giving birth to a developmentally disabled child. Karyotype analysis and interpretation of family geneologies are frequently included in this service.

Counseling, as it is provided to developmentally disabled people, is not receiving attention as a discrete service. It is sometimes provided by diagnosis and evaluation clinics, service coordinators, vocational rehabilitation workers, group home directors, and teachers. In these settings it is one of a spectrum of services provided, and documentation of the quantity, quality, or effectiveness of counseling is not systematized. Where counseling is the primary service provided, as in community mental health clinics, monitoring along the dimension of quantity is on-going to a limited extent. In these settings, however, the generic nature of the service delivery makes it difficult to document the extent to which it is available to developmentally disabled individuals.

In gathering data for this report, a questionnaire was sent to service coordinators and directors of Community Mental Health Programs asking them to assess, from their own experiences and perceptions, the extent to which services are available in their communities to developmentally disabled clients who need them. Each direct service that has been defined was rated on the following scale:

1 -- available for very few who need it
2 -- available for less than half who need it
3 -- available for more than half who need it
4 -- available for nearly all who need it.

The following graph (Figure 1) shows the mean scores of the respondents for three of the services included in this cluster.

FIGURE 1

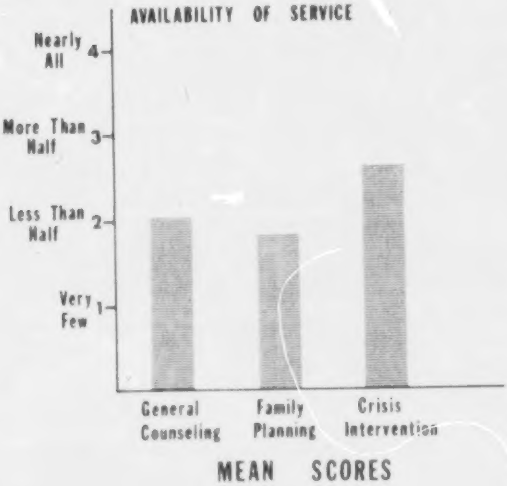


Figure 1 shows that the respondents believe that general counseling services and family planning services are available to less than half of the developmentally disabled people who need them, while crisis intervention services are available to more than half who need them.

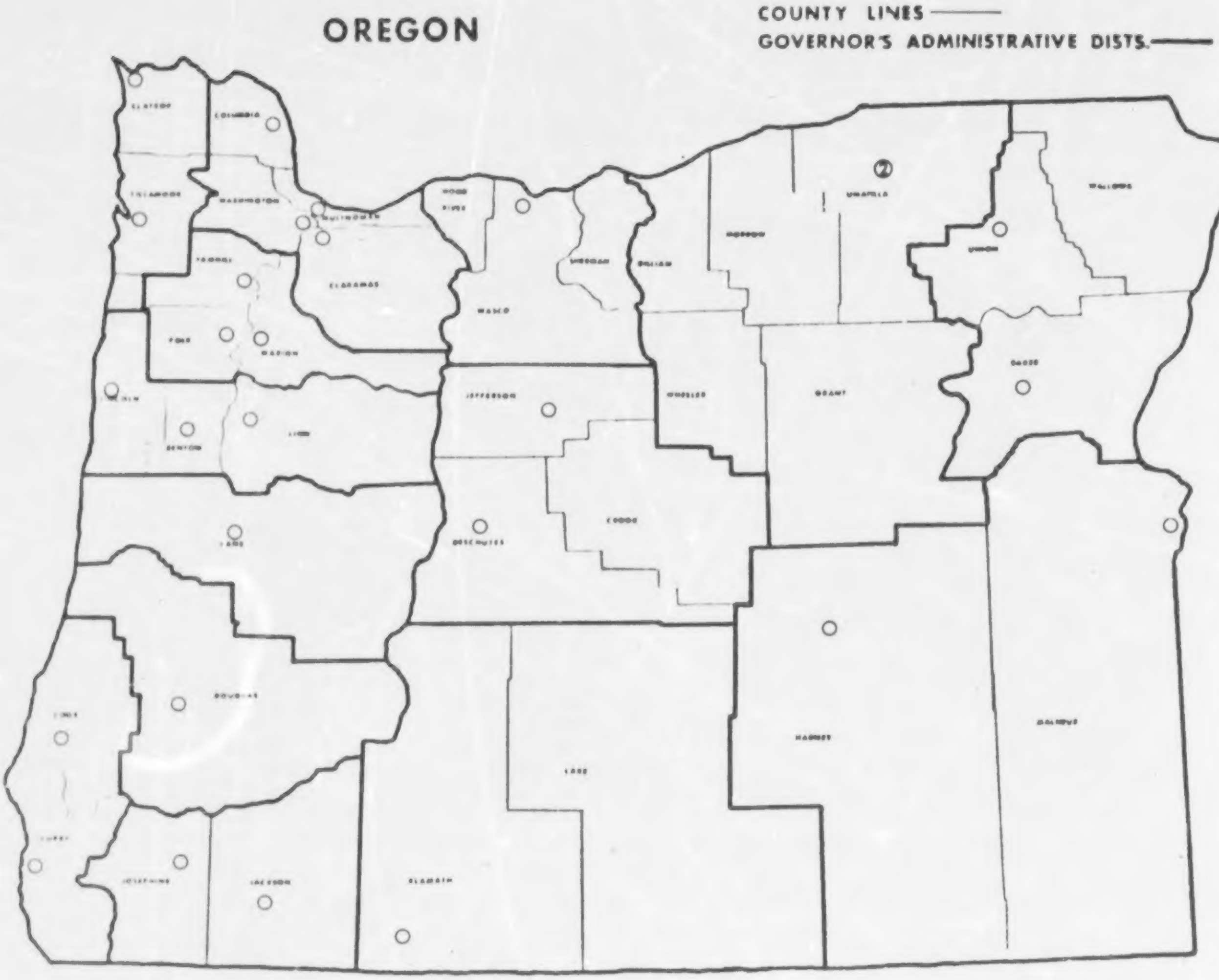
5.1 GENERAL COUNSELING

Facilities

As described above, counseling is offered in a variety of programs and facilities. It is monitored by a state agency as a discrete service in only one setting, the community mental health clinic. The Oregon Mental Health Division has responsibility for monitoring services provided through the clinics. The Annual Report for fiscal year 1972-73 provides data from 31 clinics serving all 36 counties. In Multnomah County there are four area clinics. Several counties in addition to Multnomah County contract with private and public agencies for the delivery of services. The following map shows the locations of 28 of the 31 community mental health clinics. (Three of the clinics reporting client data are not included in the directory provided by the Mental Health Division.)

FIGURE 2

LOCATIONS OF COMMUNITY MENTAL HEALTH PROGRAMS PROVIDING COUNSELING SERVICES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COLUMBIA
WASHINGTON
MULTNOMAH
CLACKAMAS
MARION
WASCO
JEFFERSON
DESCHUTES
UMATILLA
2

Clients

Oregon Mental Health Division reports that 1198 individuals who were identified as mentally retarded received services from the clinics during FY 72-73. More recent data are not available. Data on the number of clients with epilepsy or cerebral palsy are not available.

The availability of general counseling as perceived by the service coordinators and directors of Community Mental Health Programs is shown in the following graph.

FIGURE 3

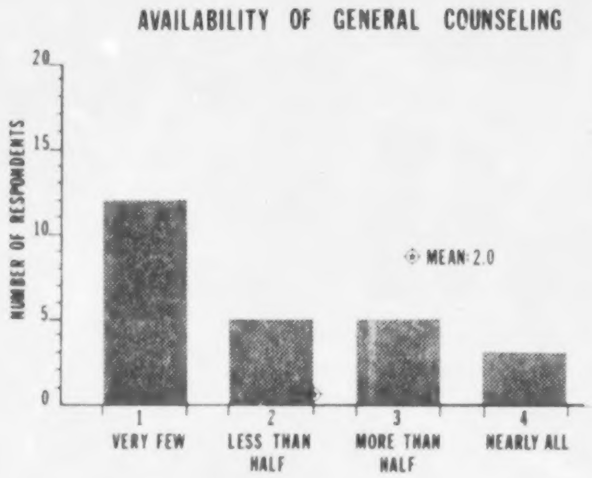


Figure 3 indicates that the most frequent response regarding availability of general counseling was "available for very few who need it."

Standards

Rules and regulations relating to Community Mental Health Programs are in the process of being redrafted by the Oregon Mental Health Division. As they read now, the draft regulations delineate responsibilities in the areas of administration, planning, and development of new services. The draft regulations describe the spectrum of services that must be provided by the mental health program as:

a) outpatient services;
b) aftercare for persons released from hospitals;
c) training, case and program consultation, and community education; and
d) guidance and assistance to other human service agencies for development of prevention programs.

As alternatives to hospitalization, it becomes the responsibility of the mental health programs, under ORS 430.630, to insure that services in the following categories are provided when needed:

a) emergency or respite services on a 24-hour basis (i.e., crisis intervention);
b) day/night programs (i.e., treatment centers, work activity centers, educational programs);
c) 24-hour residential care; and
d) out-patient services.

The draft regulations describe staffing standards for the programs. Enforcement of the standards is assured through bi-annual on-site reviews, annual contract negotiations, and individual case reports to the division.

Standards for counseling services per se are not now part of the rules and regulations.

Statement of Progress

Comparative analysis of baseline data and follow-up data is not possible. Information at both points in time was not substantive. It does appear that the responsibilities placed on the community mental health programs through HB 448 and HB 510 will affect a significant improvement in the availability of all community services for developmentally disabled people. Counseling services may then become part of the delivery system.

5.2 CRISIS INTERVENTION

5.3 FAMILY PLANNING

Agency data were not available regarding the locations of facilities providing these services, the number of clients served, or the standards which exist for the provision of service.

Data were gathered on the perceived availability of crisis intervention and family planning. The following graph shows the availability of crisis intervention as perceived by the service coordinators and directors of Community Mental Health Programs.

FIGURE 4

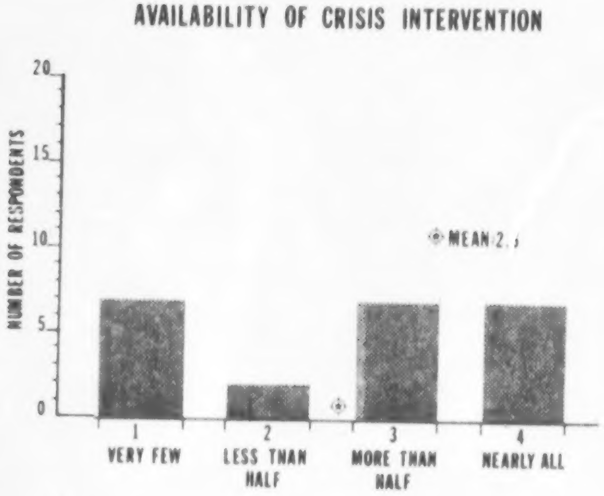
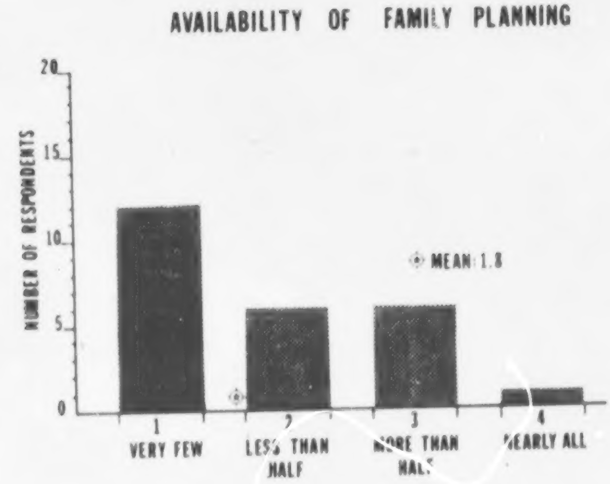


Figure 4 shows that there is a wide variation in perceived availability. Respondents who believe that the service is available for very few who need it equal the number who believe that it is available for nearly all who need it.

The availability of family planning as perceived by the services coordinators and directors of Community Mental Health Programs is shown in the following graph.

FIGURE 5



Nearly half of the respondents believe that the service is available to very few who need it.

5.4 GENETIC COUNSELING

No data were gathered regarding this service.

6.0 FAMILY SUPPORT SERVICES

The discrete services in this cluster help families to cope more effectively with the presence of a developmentally disabled person in their home. These services include both the education and training of family members, as well as temporary or part-time respite care which is designed to relieve family members from the continuous burden of providing special care. The primary objective of all the family support services is to prevent institutionalization of the disabled person.

6.0 FAMILY SUPPORT SERVICES

All services to the developmentally disabled person should include consideration and involvement of his family. There is a specific set of family related services that are provided both within and outside the home by a variety of agencies and disciplines.

Family support services include:

Family Education: Opportunities for the family to increase its knowledge and understanding of mental retardation and other developmental disabilities, and of the impact of these disabilities upon the family unit.

Family Training: A program of training for family members which provides them with the skills needed to assist the impaired person in the family. Family training offers the services provided outside of the home with a program of structured activities inside the home. In essence, family members are trained to become their own service providers.

In-home Sitter Services: Services provided for the care of an individual in his home involving temporary separation from his family for short periods of time on a regular or intermittent basis for the purpose of relieving the family of his care.

Out-of-home Sitter Services: Services provided for the care of an individual away from his home involving temporary separation from his family for short specified periods of time on a regular or intermittent basis for the purpose of relieving the family of his care.

Out-of-home Respite Care: Services provided for short-term residential care involving temporary separation of an individual from his family for specified periods of time on a regular or intermittent basis.

Homemaking: Chore and/or personal care services which must be provided to a developmentally disabled individual or his family to enable him to remain in his own home. These services may include, but are not necessarily limited to housecleaning, laundry, meal planning and preparation, feeding, bathing, shaving, dressing, etc. Services may or may not include training. This service may be provided by a certified agency such as Homemaker-Home Health Aide Services, Inc. (RT)

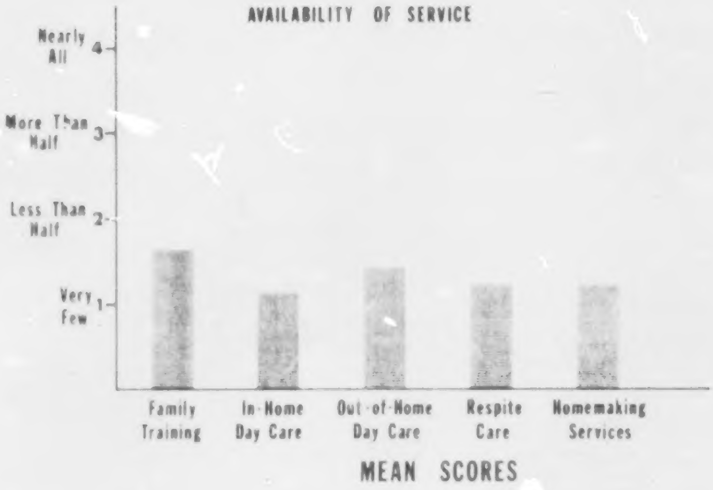
In gathering data for this report, a questionnaire was sent to service coordinators and directors of Community Mental Health

Programs asking them to assess, from their own experiences and perceptions, the extent to which services are available in their communities to developmentally disabled clients who need them. Each direct service that has been defined was rated on the following scale:

1 -- available for very few who need it
2 -- available for less than half who need it
3 -- available for more than half who need it
4 -- available for nearly all who need it.

The following graph (Figure 1) shows the mean scores of the respondents for five of the services included in this cluster.

Figure 1



As Figure 1 indicates, the respondents believe that all of the family support services investigated (Family Training, In-home Day Care, Out-of-home Day Care, Out-of-home Respite Care, and Homemaking) are available for few of the clients who need them.

6.1 FAMILY EDUCATION

Data were not collected on Family Education in this report.

6.2 FAMILY TRAINING

It has been frequently demonstrated that severely developmentally disabled people learn more rapidly and with more permanence when provided individualized instruction to meet their specific training needs. One of the principal deterrents to providing a comprehensive education to developmentally disabled children is the lack of professional staff and expertise. The professional staff limitations have led to a general recognition that one of the ways of teaching these children is through their parents.

Family training (or parent training) is a service offering a program of training for family members which provides them with the skills needed to assist another family member in the following areas: behavioral adjustment, motor development, communication, affective development, cognitive development, social skills, self-help skills, and independent living skills. Family training programs should be based on the principles of individualized programming. Parent participation should be voluntary. The effectiveness of the programs should be evaluated through continuous monitoring techniques which chart the child's behavior for the purpose of decision making (changes in program or termination of program).

Family training may be provided to the parents of developmentally disabled infants as an early intervention program or as a program leading to or supplementing placement in a center-based pre-school program. The service may also be provided to parents of school-aged children in which case it serves to supplement rather than supplant the school-based educational programs. Where the service augments a school based program, a firm training partnership between parents and classroom teacher should be established. Family training programs are designed to optimize each developmentally disabled child's progress in important living skills by helping the parent also to be a teacher, thus providing the child with cooperative and consistent learning environments.

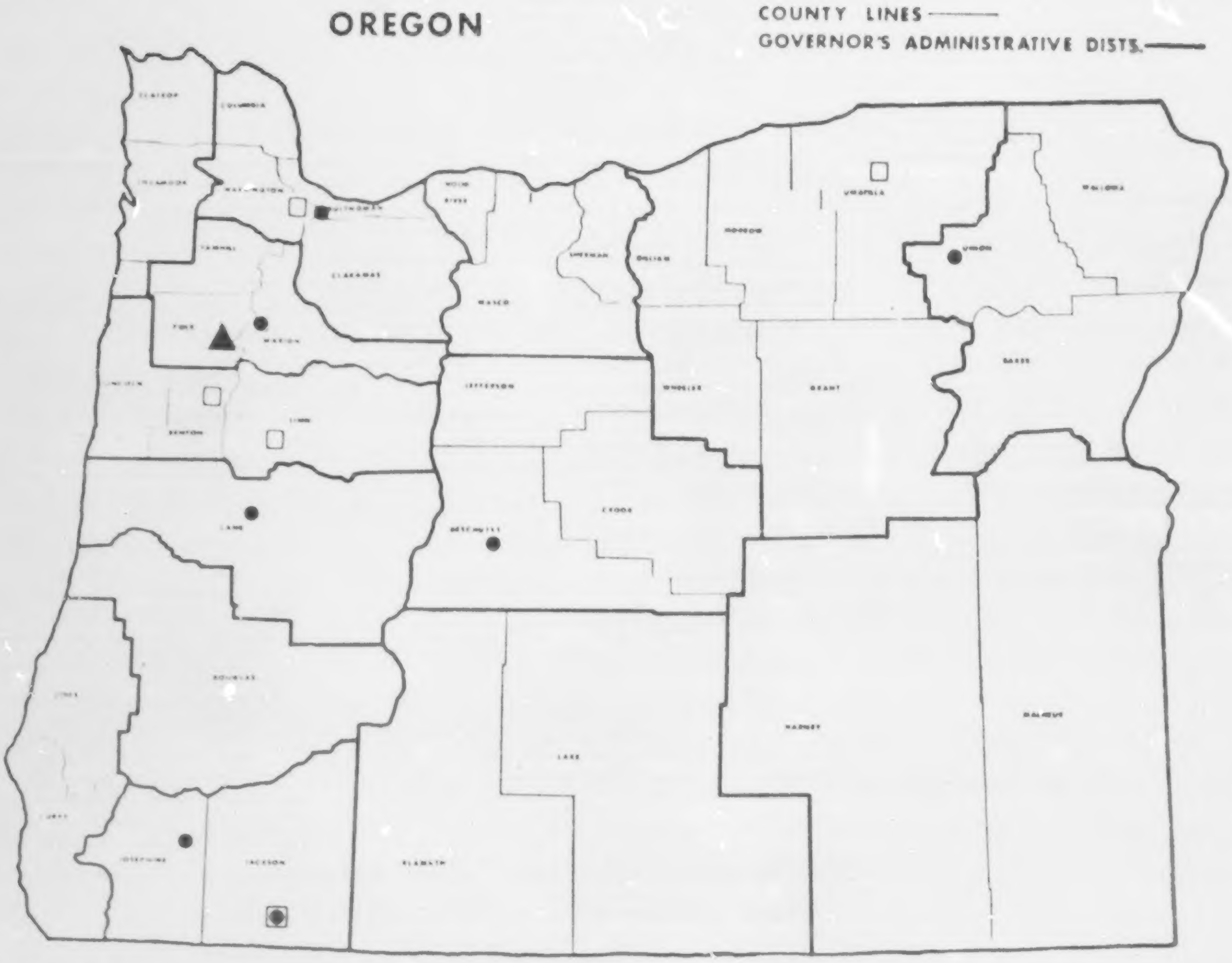
Facilities

During the 1971-72 school year, Mental Health Division implemented two parent education models: (1) parents trained by the teachers in conjunction with TMR classroom programs, and (2) parents trained by an itinerant teacher in the homes of children not enrolled in school programs. During the 1972-73 school year, some parent education was maintained in the school programs. Approximately 50 percent of the TMR teachers in Oregon were working as training partners with the parents of their students. The program was sustained most effectively in five counties: Jackson, Benton (Corvallis), Linn (Sweet Home), Umatilla (through the IED), and Washington (Beaverton). During the same year, 1972, Teaching Research developed a clinic model utilizing parents as teachers and focusing on specific skills needed for the recommended individual program plan.

In July of 1973, the Oregon Legislature demonstrated support of the parent education concept by appropriating $115,000 to the Mental Health Division's biennial budget for parent education. This money has been used to expand the most efficient of the parent education models, the Teaching Research project, in such a way as to lend support to the previously established TMR parent education programs. Consultative support will be provided for teachers including parent education in their school programs. Seven parent training specialists, trained by Teaching Research, are located in Community Mental Health Program offices with the purpose of providing on-going training, support, and follow-up to parents in their locale as well as providing assistance to teachers for initiating and implementing school-based parent training programs. The counties receiving the service are: Multnomah, Deschutes, Jackson, Marion, Josephine, Lane, and Union. The following map indicates locations of Parent Training Specialists as well as the counties which sustained parent education as part of the TMR program.

Fig. 2

Facilities Providing Family Training Services


OREGON
COUNTY LINES
GOVERNOR'S ADMINISTRATIVE DISTS.
CLATSOP
COLUMBIA
TILLAMOOK
WASHINGTON
MULTNOMAH
HOOD RIVER
SHERMAN
GILLIAM
MORROW
UMATILLA
UNION
WALLOWA
YAMHILL
CLACKAMAS
WASCO
POLK
MARION
LINCOLN
BENTON
LINN
JEFFERSON
WHEELER
GRANT
BAKER
CROOK
LANE
DESCHUTES
DOUGLAS
COOS
CURRY
JOSEPHINE
JACKSON
KLAMATH
LAKE
HARNEY
MALHEUR

● Parent Training Specialists

☐ Parent Education in TMR Program

▲ Core Clinic

Family training is also seen by the Crippled Children's Division as "part and parcel" of its diagnostic and evaluation services. To varying degrees each of the families who bring children to the Center is offered training depending on the family's needs and the facility's ability to provide the service. In most instances this service might be facilitated through the services coordinator and/or the Children's Services worker when this service cannot be given directly by members of the clinic staff. Data on specific locations of programs was not provided.

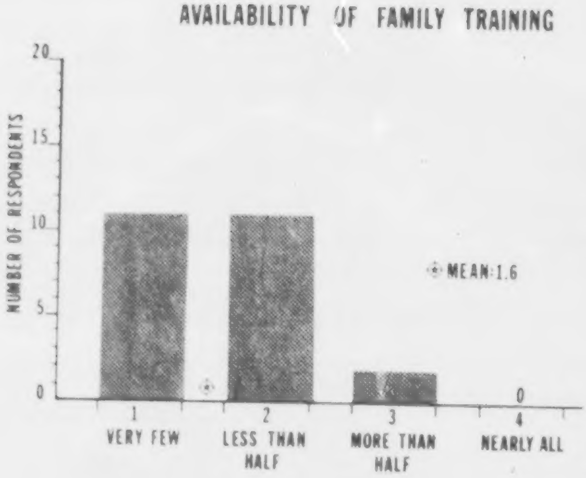
Clients

Information regarding the number of clients receiving parent training services is not available by county, age, or disability. Data have been provided by Mental Health Division and by Teaching Research concerning the total number of clients served during the year. The Mental Health Division reported that 688 clients, ages 0-21, were involved in the TMR parent education program. The Teaching Research Behavioral Clinic, in Monmouth, provided parent training programs for 71 families during the six months from July 1 to December 31, 1973. The Parent Training Specialist program was implemented in December of 1973 and, consequently, had no client base during the reporting period. It is expected that the seven specialists will provide services, directly or indirectly, to 600 clients.

No data are available at this time concerning the number of families participating in parent training programs through Crippled Children's Division.

The availability of family training services as perceived by the service coordinators and directors of Community Mental Health Programs is shown in the following graph.

Fig. 3



As Figure 3 shows, nearly all of the respondents rated the service as being available for very few or less than half of those who need it.

Standards

Standards for parent training programs have been established by the Mental Health Division. They are described in three documents: (1) Parent Education Program Guidelines, (2) Parent Training Specialist Job Description, (3) Training Priorities for Parent Training Specialists.

Standards are enforced through individual case reports, on site reviews, and on-going in-service training. Enforcement of the standards is the responsibility of the Mental Health Division.

Statement of Progress

With the legislative allocation of funds in July, 1973 and the implementation of the Parent Training Specialists proposal, family training services will be available to perhaps half again as many clients as received those services in 1972-73. The legislative action extended the service beyond the school based (TMR and DD Pre-school) parent training programs to include now parents of developmentally disabled children who are not enrolled in school programs, parents of pre-school and school age children who are not developmentally disabled but have severe behavior deficits.

Guidelines for the delivery of the service and for evaluating the delivery of the service have been developed during the last six months. Responsibility rests with the Mental Health Division to provide and monitor these programs. There are, however, other agencies involved in family training services (Crippled Children's Division as the major participant). Communication and/or coordination among the programs must be established and perhaps formalized in order to maximize resources.

6.3 IN-HOME DAY CARE

Where it is available, in-home day care (sitter service) has developed at the community level primarily through the efforts of volunteer agencies. It is not part of the state-wide service delivery system, and, consequently, no state agency has responsibility for delivering or monitoring the service. No data were available regarding the locations where in-home day care services are available or the number of clients receiving the service.

There are no state-wide standards for the quality of care provided through in-home day care services. Where services have developed locally (Lane County for example), a training program for sitters is available but standards for care have not been developed.

Data were collected on the perceived availability of in-home day care through the questionnaires sent to service coordinators and directors of Community Mental Health Programs. The following graph shows the frequency of responses.

Fig. 4

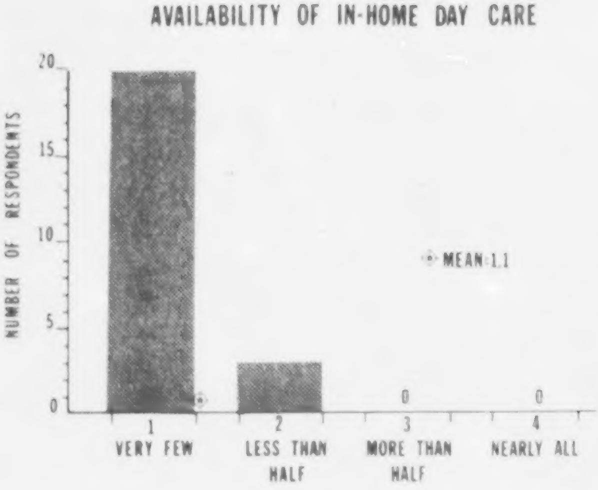


Figure 4 clearly indicates that almost all of the respondents believe that in-home day care is available for very few of those who need it.

6.4 OUT-OF-HOME DAY CARE

As with in-home day care, out-of-home day care is a service which may be developed out of local community interest. It is not part of a state-wide system of service delivery or monitoring.

Facilities

No data are available through a state agency as to the location of facilities providing out-of-home day care in the community. In one case where the service has been developed locally, a special facility provides respite day care. Three State Hospital and Training Centers, Columbia Park in The Dalles, Eastern Oregon MR Unit in Pendleton, and Fairview in Salem, are authorized to provide out-of-home day care. The state facilities are used minimally for that service.

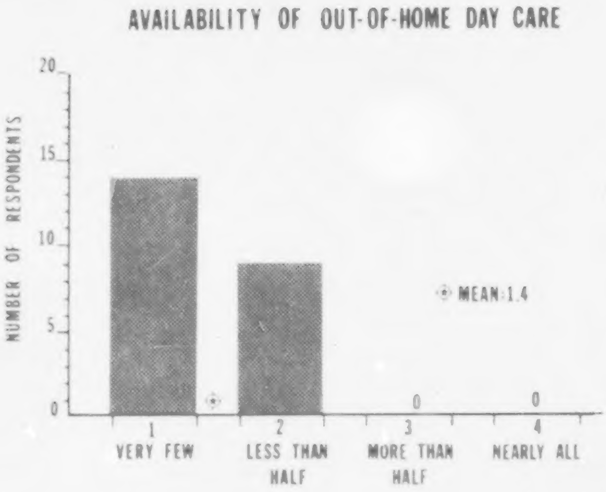
Clients

Data were provided by the Mental Health Division concerning the utilization of the State Hospital and Training Centers for out-of-home day care. The Division reports that one client received this service through the centers during the period between July 1, 1973 and December 31, 1973.

There is some indication that locally developed facilities providing out-of-home day care have difficulty sustaining the programs financially. This is due in some part to the regulations of Children's Services Division and Public Welfare Division that disallow payment for services to a facility that serves both children and adults.

The availability of out-of-home day care as perceived by the service coordinators and directors of Community Mental Health Programs is shown in the following graph.

Fig. 5



As Figure 5 shows, most of the respondents believe that the service is available to very few who need it.

Standards

Standards are available for out-of-home day care as the service is provided through the state hospital and training centers. Documents relating to facilities, staffing, and programming are: "Standards for Residential Facilities for Mentally Retarded" by the Joint Commission on Accreditation of Hospitals (JCAH) and Rules and Regulations for licensing of Nursing Homes for the Mentally Retarded set forth by the Oregon Health Division. Responsibility for enforcement of the standards rest with those two bodies. The standards are enforced through license renewals by the Health Division and accreditation by JCAH.

6.5 OUT-OF-HOME RESPITE CARE

Out-of-home respite care offers 24-hour residential care for the purpose of giving temporary relief from responsibility to the family of a handicapped person. Provision of this service in the community is not monitored by a state agency. The service is provided by the state hospital and training centers, and, in those settings, is monitored by the Oregon Mental Health Division.

Facilities

No data are available on the locations of community based facilities offering out-of-home respite care.

Data has been provided by the Mental Health Division as to the use of state hospital and training centers for out-of-home respite care. Three centers provide the service: Columbia Park Hospital and Training Center in The Dalles, Eastern Oregon Hospital and Training Center (Mental Retardation Unit) in Pendleton, and Fairview Hospital and Training Center in Salem.

Clients

The three state facilities provided out-of-home respite care to 16 developmentally disabled clients between July 1, 1973 and December 31, 1973. The perceived availability of Out-of-home Respite Care is shown in the following graph.

Fig. 6

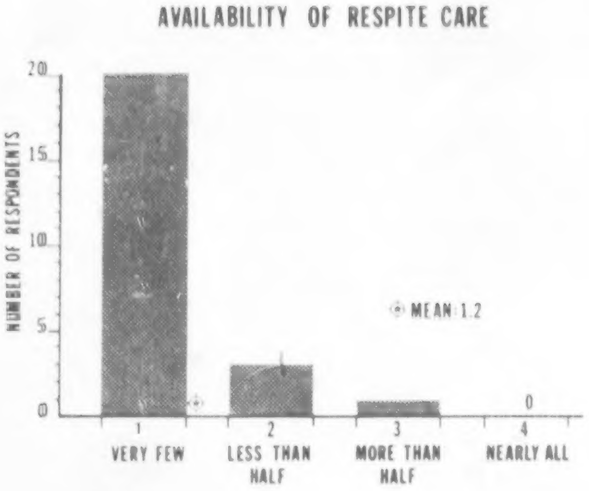


Figure 6 indicates that nearly all of the respondents believe that the service is available for very few of those who need it.

Standards

Standards for out-of-home respite care provided by the state hospital and training centers come under the same jurisdiction as those described in Section 6.3 of this report (Standards).

6.6 HOMEMAKING

As with the other respite care services, homemaking is not part of the state's service delivery system. No agency has responsibility for assuring the provision or monitoring the delivery of homemaking services. The service is beginning to receive some attention from the Health Division, but it is only provided by that agency in conjunction with health related or training related services.

There is no documentation available through the Health Division regarding locations of service providers, number of clients served, or standards relating to the delivery of homemaking services.

The availability of homemaking services as perceived by the service coordinators and Community Mental Health Program Directors is shown below.

Figure 7

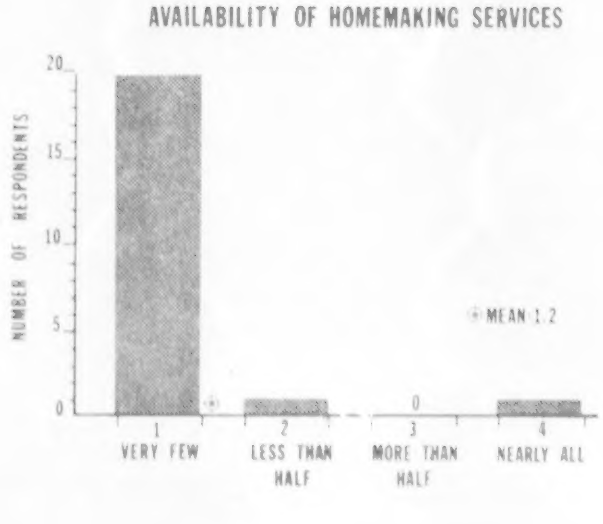


Figure 7 shows that nearly all of the respondents believe that homemaking services are available to very few who need it.

7.0 LIVING ARRANGEMENTS

The discrete services in this cluster provide a wide range of living arrangements for developmentally disabled persons. The various alternatives represent a continuum one end of which provides an opportunity for nearly independent living while the other end provides a living environment in which the impaired person's activities are almost entirely managed by other people.

7.0 LIVING ARRANGEMENTS

It is the right of every developmentally disabled person to enjoy the dignity, respect and opportunities accorded all people by the freedoms and privileges of our society. To the extent that developmentally disabled individuals differ in levels of independence and severity of disability, varying degrees of supervision and programming are needed in community residences. The spectrum of residential programs characteristically includes the following:

> Board and Room Living: A living situation for those individuals who can maintain or remain in an essentially unsupervised living situation. Participation in a community resource such as an Activity Center may be needed to sustain this level of independence.
>
> Group Home Care: A closely supervised living situation in a facility serving not less than six clients. Since the goal of this program is semi-independent living, training must also be provided or made available to residents in the following areas: self-help skills, independent living skills, social behaviors, communication, education, vocational training and adjustment, recreation, and community orientation.
>
> Foster Care: A family home which is willing to accept not more than five persons needing supervision within the context of a program of supporting services. The program of supplemental services for each resident can be provided on contract over and above the regular room and board rate.
>
> Sheltered Care: A facility which provides residential care on a long-term basis for highly dependent persons without severe medical problems. The program of services should include stimulation of abilities and comprehensive recreational activities.
>
> Nursing Home Care: A facility of six bed capacity or more which is intended for the residential care, treatment, and training of dependent persons. The facility is geared to serving the needs of persons with severe physical handicaps or medical problems on a relatively long-term basis. The program of services should provide special medical attention, stimulation of abilities, and comprehensive recreational opportunities based on the general needs of the residents.

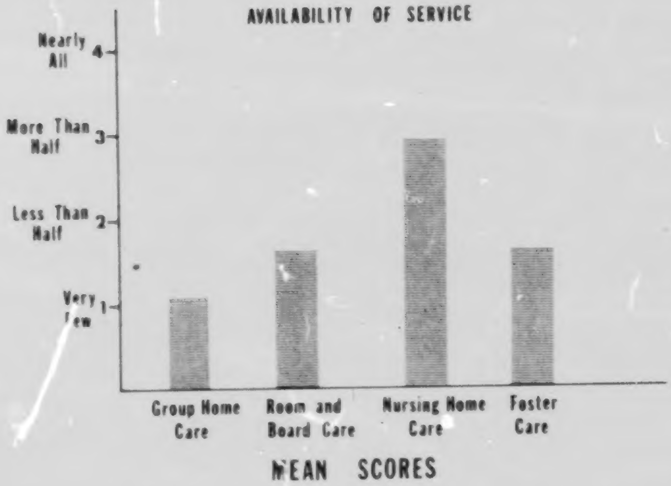
Institutional Care: A self-contained facility, usually large in size, which provides residential care, medical treatment, and training for developmentally disabled people. (RT)

In gathering data for this report, a questionnaire was sent to service coordinators and directors of Community Mental Health Programs asking them to assess, from their own experiences and perceptions, the extent to which services are available in their communities to developmentally disabled clients who need them. Each direct service that has been defined was rated on the following scale:

1 -- available for very few who need it
2 -- available for less than half who need it
3 -- available for more than half who need it
4 -- available for nearly all who need it.

The following graph (Figure 1) shows the mean scores of the respondents for four of the services included in this cluster.

Figure 1



As Figure 1 indicates, the respondents expressed the following perceptions:

- --that Board and Room Care and Foster Care are available for few of those who need it;
- --that Group Home Care is available for very few who need it;
- --that Nursing Home Care is available for more than half who need it.

7.1 BOARD AND ROOM CARE

7.2 GROUP HOME CARE

For the purposes of this report, board and room facilities and group homes are considered together. Each setting provides shelter, food, and some degree of supervision. The differences in programming reflect the abilities of the clients served in each program to function independently in the community.

The move toward deinstitutionalization and normalization of developmentally disabled people has caused state agencies to sharpen their concern about the availability of community living facilities and the application of standards to the operation of the facilities. While board and room facilities and group homes have been in operation for some time, they are just recently becoming part of a system where they will be monitored as to the quantity, quality and effectiveness of services offered.

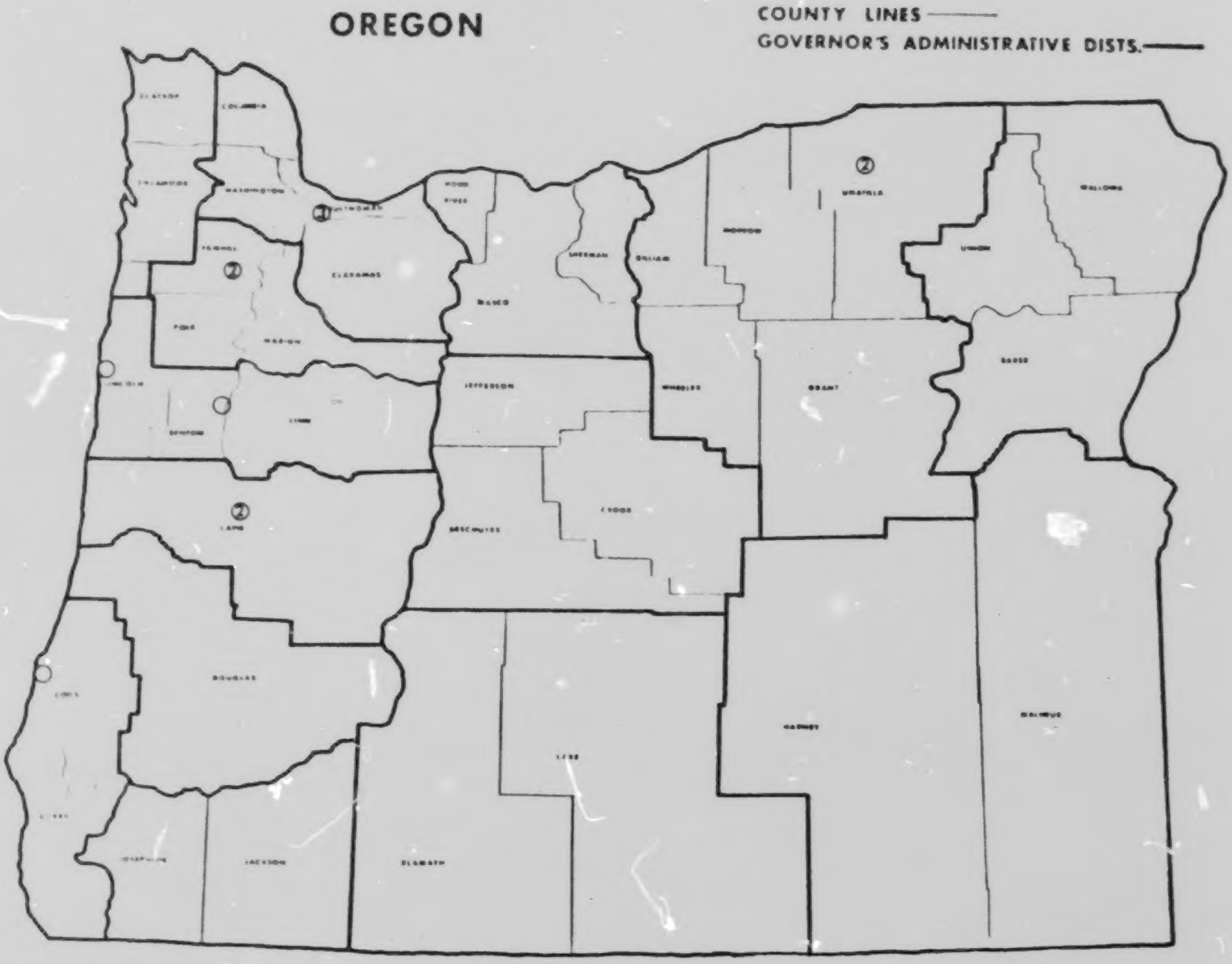
Facilities

While there are many facilities in the state providing board and room and group home care, only a small portion of them are currently under the jurisdiction of a state agency. The Oregon Health Division has authority for licensing nursing home facilities for the mentally retarded. The authority extends to group homes as well. To include the latter, however, it has been necessary to revise the rules. The revision is in progress; until it is completed many community residential facilities are operating without licensing by the Health Department.

Twelve group homes are receiving funding (and are monitored as to quality of service) through the Mental Health Division. The following map shows the locations of these facilities. Data were not provided as to how many of the group homes funded by Mental Health Division are licensed by the Health Division.

Figure 2

Facilities Providing Group Home Care


OREGON
COUNTY LINES
GOVERNOR'S ADMINISTRATIVE DISTS.
②
②
②
②

LOCATIONS OF GROUP HOMES
FUNDED BY MENTAL HEALTH DIVISION

Clients

The data provided by Mental Health Division indicate that 95 developmentally disabled people are being served through ten of the group homes that the Division funds. All of the clients are over 18 years of age. Data were not provided for the two group homes in Benton County. Table 1 in the appendix shows the breakdown of client characteristics by age and disability.

Data are not available regarding the number or characteristics of clients residing in board and room facilities.

The availability of group home care and board and room care as perceived by the service coordinators and directors of Community Mental Health Programs is shown in the following graphs.

Figure 3

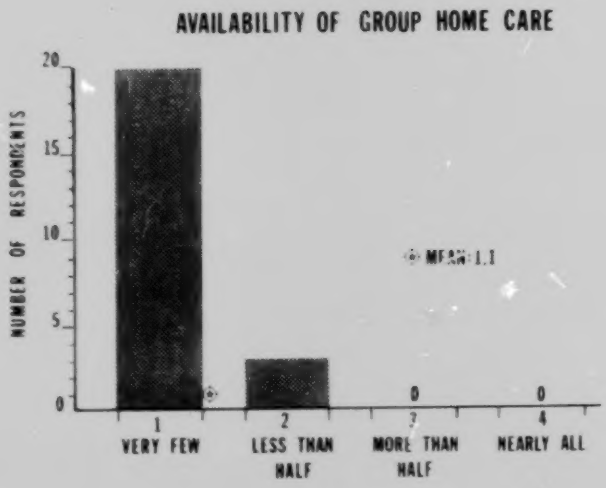
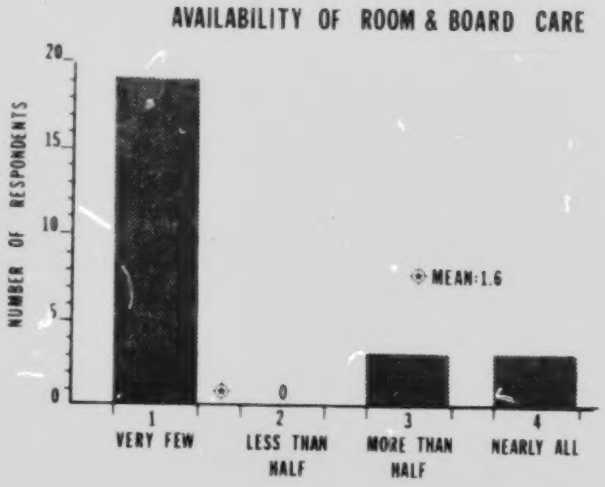


Figure 3 indicates that nearly all of the respondents believe that group home care is available for very few who need it.

Figure 4



As Figure 4 shows, most of the respondents believe that Board and Room Care is available for very few of those who need it.

Standards

The Oregon Health Division with the cooperation of the Mental Health Division and the Developmental Disabilities State Council is in the process of developing new licensing standards for community residential facilities. The proposed rules discuss administration, staffing patterns, facility standards, programming, and supportive services. They have not yet been adopted by the Health Division.

The Mental Health Division has also implemented a client programming and evaluation system in the group homes funded by them. Using a track profile, the group home operator is able to assess training needs for each client and to evaluate client progress through monthly checks. The Division periodically monitors the use of the track profile. The profile describes level of function (degree of independence) across the following characteristics: self care, motor skills, social skills, communicative skills, self-direction, and deviant behavior. The use of the track profile allows the operators and the Division to evaluate programs in terms of client outcomes.

7.3 FOSTER CARE

Foster care is available for developmentally disabled adults and children in Oregon. The Public Welfare Division is responsible for adult foster placement; Children's Services Division is responsible for foster placement for children. Neither agency maintains records on clients who are in foster care regarding type or degree of handicap.

Facilities

The current list of adult and group foster homes available through Public Welfare Division does not distinguish homes serving developmentally disabled people nor does it imply that all of the facilities are caring for persons known to Public Welfare.

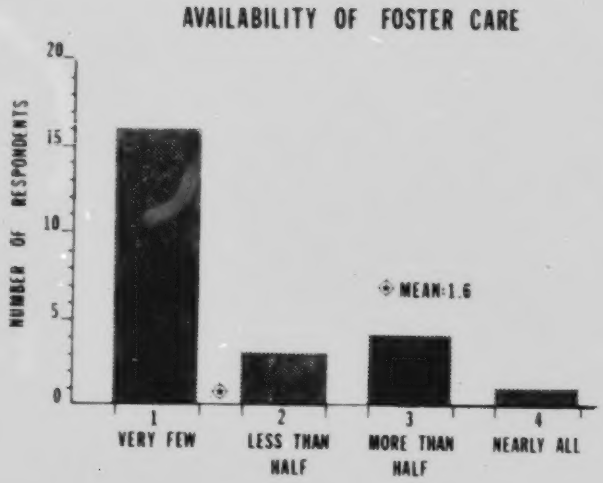
Children's Services Division could not provide data on the number or locations of foster homes serving developmentally disabled children.

Clients

Neither agency responsible for foster care could provide data on the number or characteristics of clients receiving that service. Children's Services Division reported that they do not serve developmentally disabled children as a target population but only as they may be eligible under the criteria applied to the whole population of children between 0 and 21 years. The agency does not maintain records as to type or degree of disability of children who are receiving services.

The perceived availability of foster care services is shown in the following graph.

Figure 5



As Figure 5 shows, most of the respondents believe that foster care is available to very few of those who need it.

Standards

The agencies responsible for foster care did not provide information as to the standards used in providing or monitoring the service.

7.5 NURSING HOME CARE

As with board and room facilities, there are many nursing homes in the state providing care for developmentally disabled people. Most of these facilities are private businesses, and consequently few of them are monitored as to standards of care, training opportunities available to residents, or the number and characteristics of residents receiving services. No data were available as to locations of nursing homes serving developmentally disabled clients, the number of clients being served, or the extent to which nursing homes comply with licensing standards.

Responsibility for nursing home care standards rests with the Health Division. Nursing home facilities fall under the same regulations as other group care homes which are discussed in section 7.2 of this report.

The availability of nursing homes as perceived by the service coordinators and directors of Community Mental Health Programs is shown in the following graph.

Figure 6

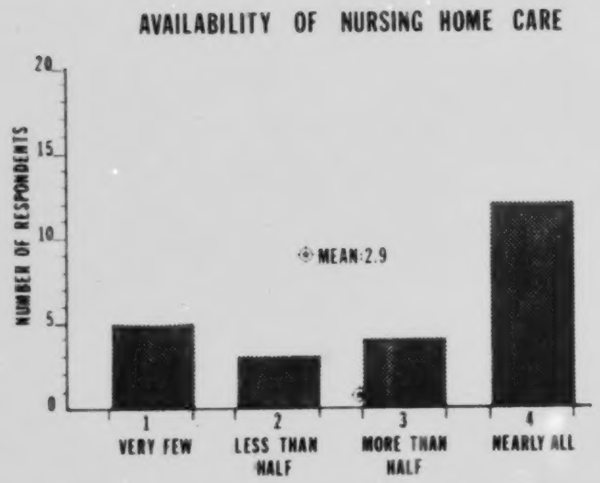


Figure 6 indicates that half of the respondents believe that nursing home care is available for nearly all who need it.

7.4 SHELTERED CARE

7.6 INSTITUTIONAL CARE

Data were not collected on these two services.

APPENDIX

Table 1

CLIENTS SERVED IN GROUP HOMES FUNDED BY MHD

	MR	CP	E	Multiply* Handicapped	TOTAL
18-44 years	55	4	2	28	89
45+ years	4	0	0	2	6
TOTAL	59	4	2	30	95

*Multiply Handicapped refers to those persons who are affected by a combination of two or more of the disabilities mental retardation, cerebral palsy, and/or epilepsy.

8.0 VOCATIONAL SERVICES

The discrete services in this cluster assist an impaired person in finding employment or other meaningful adult occupation. Economic self-sufficiency, whenever possible, is a major goal of these services. Achievement of the maximum occupational satisfaction possible for the impaired person, with or without remuneration, is also a major goal of these services.

8.0 VOCATIONAL SERVICES

Vocational services involve activities which lead to the employment or other meaningful occupation of an adult. The activities should begin before adulthood. Developmentally disabled young people should have vocational development opportunities available to them as part of intermediate and secondary school programs. Vocational services should be available for all developmentally disabled people regardless of severity of disability.

The spectrum of services included in vocational development are:

> Evaluation: A systematic appraisal of an individual's employability for the purpose of appropriate occupational placement or for devising an individualized program of training. Evaluation determines expected limitations upon an individual's vocational potential, and the extent to which these limitations can presumably be removed, corrected, or minimized by specific intervention services.
>
> Training: An individualized program of action designed to increase a person's employability by removing, correcting, or minimizing problems which can be expected to limit the individual's work activities. The program may include prevocational and occupational skills training as well as work adjustment training.
>
> Placement: Services which assist an individual in finding employment that is consistent with his capabilities and interests; placement services follow individual evaluation and, where needed, training programs.
>
> Sheltered Employment: A structured program of activities involving: (1) short-term remunerative employment designed to affect placement in the competitive labor market, or (2) extended, long-term remunerative work in a protective environment.
>
> Activity Center Program: An organized program which provides dignified and meaningful work, social, and recreational activities on a daily basis for adults who are not yet ready to engage in competitive or sheltered employment.

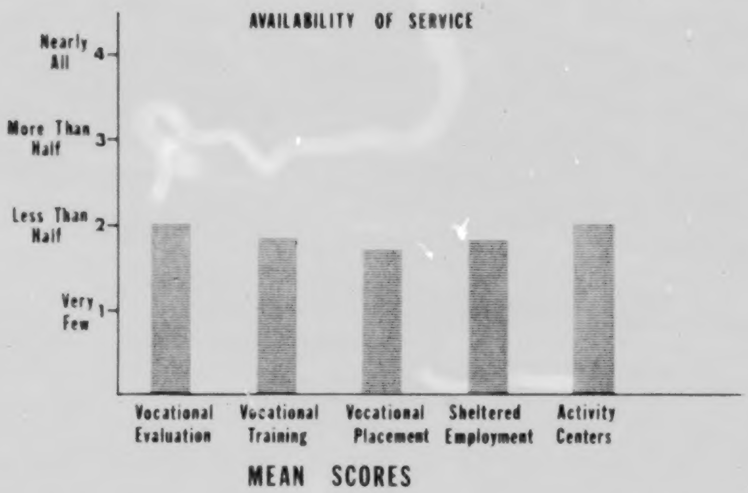
A single agency may provide one or more of these services as its primary service(s). Or one of the vocational development services may be offered by an agency as an ancillary service to another major program (for example, vocational evaluation, training and/or placement may be part of a group home program). Data have been provided on vocational services where they are a primary service.

In collecting data for this report, a questionnaire was sent to service coordinators and directors of Community Mental Health Programs asking them to assess, from their own experiences and perceptions, the extent to which services are available in their communities to developmentally disabled clients who need them. Each direct service that has been defined was rated on the following scale:

1 -- available for very few who need it
2 -- available for less than half who need it
3 -- available for more than half who need it
4 -- available for nearly all who need it.

The following graph (Figure 1) shows the mean scores of the respondents for the five services included in this cluster.

Figure 1



As the graph indicates, the respondents believe that all of the vocational services are available for less than half of the people who need them.

8.1 VOCATIONAL EVALUATION

The Oregon Vocational Rehabilitation Division provides for and monitors vocational evaluation throughout the state. Responsibility for most vocational development services rests with that agency. The division provided data concerning facilities, clients, and standards for vocational evaluation as well as the other vocational development services that it monitors.

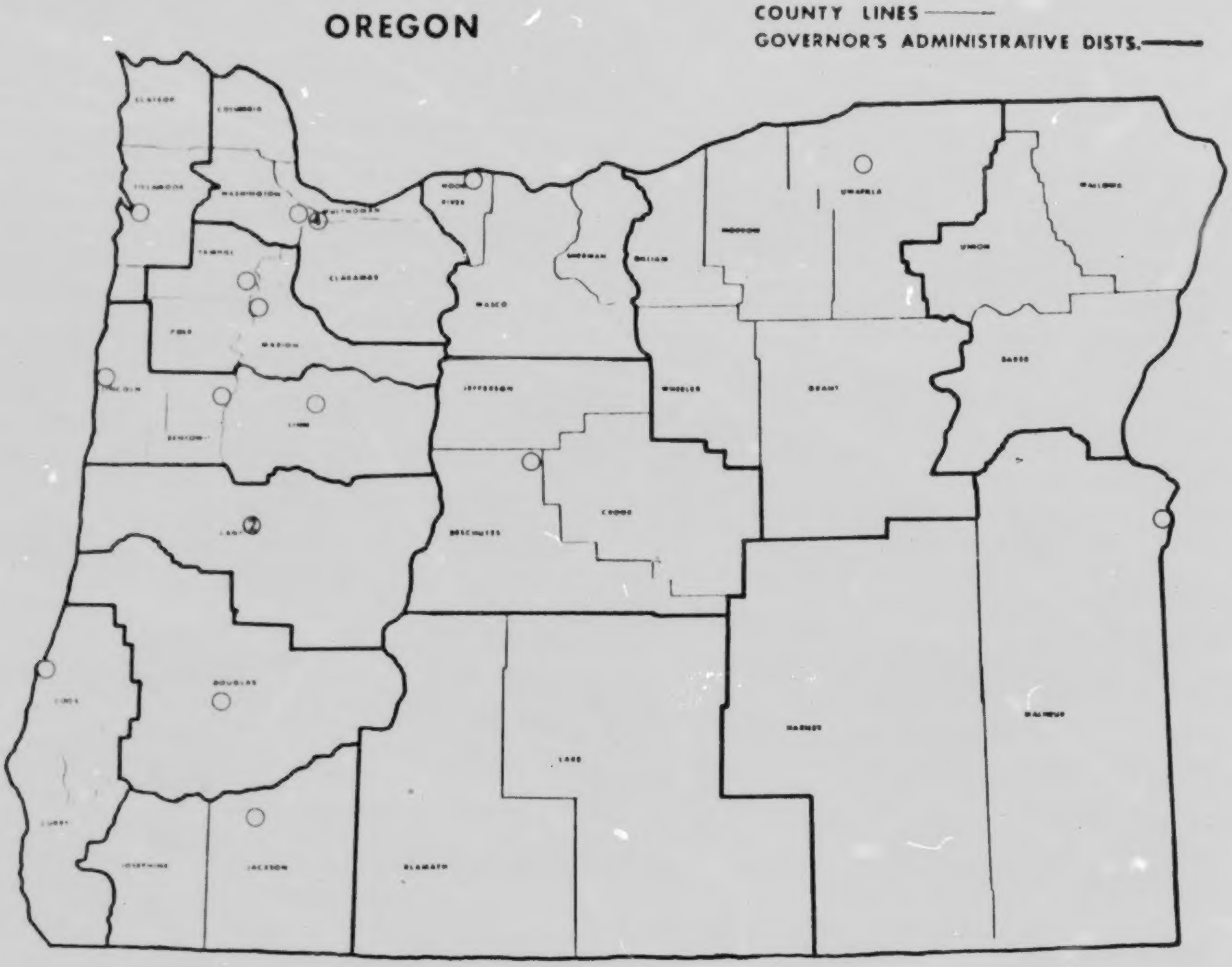
Work evaluation, as discussed in the Division's standards, means assessing the client's productive potentiality through the medium of work in order to determine his physical and emotional strengths and weaknesses, to determine his ability to learn work operations or acquire skills, and to assist in determining his areas of job interests. Work evaluation implies an orderly process to assess the vocational potential of a given client. In this sense, it is a process distinct from the ongoing evaluation designed to measure progress within a rehabilitation plan.

Facilities

The Vocational Rehabilitation Division purchases evaluation services for developmentally disabled people from facilities throughout the state. At the time the data were reported, twenty facilities in 16 counties were providing the service. The map on the following page shows the locations of the facilities.

Figure 2

FACILITIES PROVIDING VOCATIONAL EVALUATION SERVICES


OREGON
COUNTY LINES
GOVERNOR'S ADMINISTRATIVE DISTS.
CLATSOP
COLUMBIA
TILLAMOOK
WASHINGTON
MULTNOMAH
4
HOOD RIVER
UMATILLA
WALLOWA
YAMHILL
CLACKAMAS
WASCO
SHERMAN
GILLIAM
MORROW
UNION
POLK
MARION
LINCOLN
BENTON
LINN
JEFFERSON
WHEELER
GRANT
BAKER
CROOK
DESCHUTES
LANE
2
DOUGLAS
COOS
CURRY
JOSEPHINE
JACKSON
KLAMATH
LAKE
HARNEY
MALHEUR

Clients

During the six months between July 1, 1973 and December 31, 1973, Vocational Rehabilitation Division provided for evaluation services for 2,016 individuals who are developmentally disabled. Table 1, following, shows the distribution of clients served in each Mental Health Region and the relationship of that figure to the total served and the total population of each region and the state.

TABLE 1

DVR CLIENTS RECEIVING VOCATIONAL EVALUATION, 7/1/73 - 12/31/73

	Number Served	% of Total Served	Population in Region	% of Total Population
Region 1	760	37.7	909,465	43.5
Region 2	1,102	54.7	1,015,037	48.5
Region 3	154	7.6	166,875	8.0
TOTAL STATE	2,016	100.0%	2,091,377	100.0%

Table 1 indicates that, relative to the population distribution, Mental Health Region 2 received a disproportionately large share of the evaluation services while service in Region 1 was disproportionately low.

Table 7 in the appendix shows age and disability characteristics of the clients receiving evaluation services through Vocational Rehabilitation Division.

The availability of this service as perceived by the service coordinators and directors of Community Mental Health Programs is shown in the following graph.

Figure 3

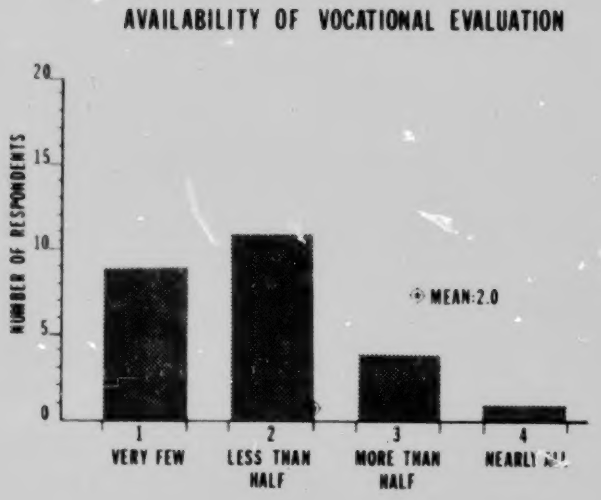


Figure 3 indicates that most of the respondents believe that evaluation services are available for less than half or very few of the clients who need them.

Standards

Standards have been developed and published by the Vocational Rehabilitation Division for rehabilitation facilities in Oregon. The document offers standards and criteria for services (intake, work evaluation, training of occupational skills, work adjustment training, selective placement, sheltered employment, and work activities), staffing, organization and administration, records and reports, fiscal management, physical facilities, safety, and community relations. The standards are enforced through periodic on-site evaluations (every three years for fully qualified facilities; every year for others). Seventeen of the twenty facilities were meeting the standards at the time data were provided. The three facilities not determined to be meeting standard were new facilities which had not yet been evaluated.

8.2 VOCATIONAL TRAINING

Trade training or occupational training means instructional services designed to teach clients those skills, knowledge, and abilities normally necessary to ply a recognized trade or occupation. This training is distinct from work adjustment training in its goals, and the adjustment training normally precedes the occupational training though it is conceivable that the two can be provided concurrently. Work adjustment training means using actual jobs and the work environment to develop acceptable work patterns, acquiring suitable attitudes and personal habits necessary in the work world, and acquiring the ability to relate to the social environment which accompanies a work situation.

Facilities

Training (both occupational and work adjustment) may take place in a variety of settings: i.e., workshops, community colleges, or on the job. The Vocational Rehabilitation Division was not able to provide data on the locations of facilities where training takes place. For the most part, the facilities shown on the map in section 8.1 (Facilities) provide training as well as evaluation services.

Clients

During the first six months of FY 74 the Vocational Rehabilitation Division provided for training services to 536 developmentally disabled people. Table 8 in the appendix shows the breakdown of client characteristics by age and disability. Table 2, below, shows the distribution of clients who received training according to Mental Health Region and the relationship of those figures to the total served and the total population of the regions and the state.

TABLE 2

DVR CLIENTS RECEIVING VOCATIONAL TRAINING, 7/1/73 - 12/31/73

	Number Served	% of Total Served	Population in Region	% of Total Population
Region 1	192	35.8	909,465	43.5
Region 2	308	57.5	1,015,037	48.5
Region 3	36	6.7	166,875	8.0
TOTAL STATE	536	100.0%	2,091,377	100.0%

Table 2 indicates that, relative to population distribution clients in Mental Health Region 2 received a disproportionate share of vocational training services while Regions 3 and 1 received proportionally less.

The availability of this service as perceived by the service coordinators and directors of Community Mental Health Programs is shown in the following graph.

Figure 4

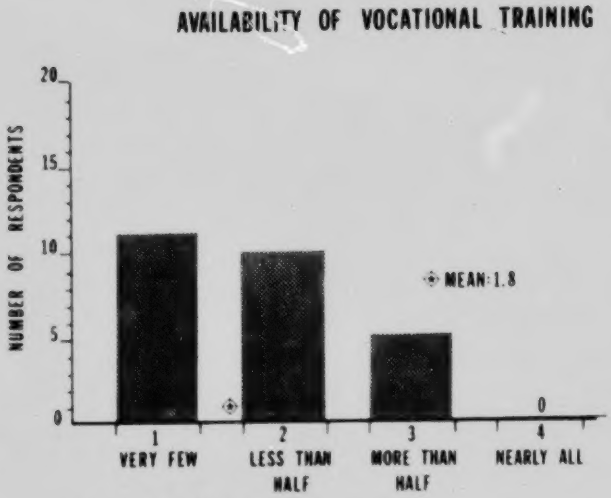


Figure 4 indicates that most of the respondents believe that vocational training services are available for very few or less than half of those who need them.

Standards

Standards for vocational training are published and enforced by Vocational Rehabilitation Division as discussed in section 8.1 (Standards).

10.3 VOCATIONAL PLACEMENT

Placement means assisting the client to find and hold a job consistent with his abilities and interests. This may mean competitive employment or it may mean extended sheltered employment. In Oregon, two state agencies provide and monitor placement services: the Oregon Employment Division and Vocational Rehabilitation Division.

Facilities

The Oregon Employment Division has 43 offices throughout the state. Of these, approximately 40 are used by developmentally disabled persons for placement. (The offices also offer minimal evaluation/assessment service to determine job suitability.)

The Vocational Rehabilitation Division assures the provision of placement services for developmentally disabled people through the twenty rehabilitation facilities noted on the map in section 10.1 (Facilities).

Clients

Placements of developmentally disabled persons made through the Employment Division tend to serve job ready, mildly impaired individuals. Table 9 in the appendix shows the distribution of clients (numbers estimated) by disability. Table 3 below shows the distribution of clients served by the Employment Division (estimated figures) according to Mental Health Region and the relationships of those figures to total served and the total population of region and state.

TABLE 3

OED CLIENTS RECEIVING PLACEMENT SERVICES
JULY 1, 1973 TO DECEMBER 31, 1973

	Number Served	% of Total Served	Population in Region	% of Total Population
Region 1	81	41.1	909,465	43.5
Region 2	95	48.2	1,015,037	48.5
Region 3	21	10.7	166,875	8.0
TOTAL STATE	197	100.0%	2,097,377	100.0%

The table indicates that clients in Mental Health Region 3 receive a slightly higher share of placement services in proportion to the population while those in Region 1 receive a slightly lower share.

During the six months period between July 1, 1973 and December 31, 1973, Vocational Rehabilitation Division provided placement services for 187 developmentally disabled people. Table 10 in the appendix shows the breakdown of the client figures by age and disability. Table 4, following, shows the distribution of clients served across the Mental Health Regions and the relationship of those figures to the total served and the total population of the regions and the state.

TABLE 4

DVR CLIENTS RECEIVING PLACEMENT SERVICES, 7/1/73 - 12/31/73

	Number Served	% of Total Served	Population in Region	% of Total Population
Region 1	75	40.1	909,465	43.5
Region 2	103	55.1	1,015,037	48.5
Region 3	9	4.8	166,875	8.0
TOTAL STATE	187	100.0%	2,091,377	100.0%

Table 4 indicates that, relative to population distribution, Mental Health Region 2 receives a disproportionate share of placement services while Region 1 and especially Region 3 receive proportionally less.

The perceived availability of sheltered employment, as rated by service coordinators and Community Mental Health Directors is shown below.

Figure 5

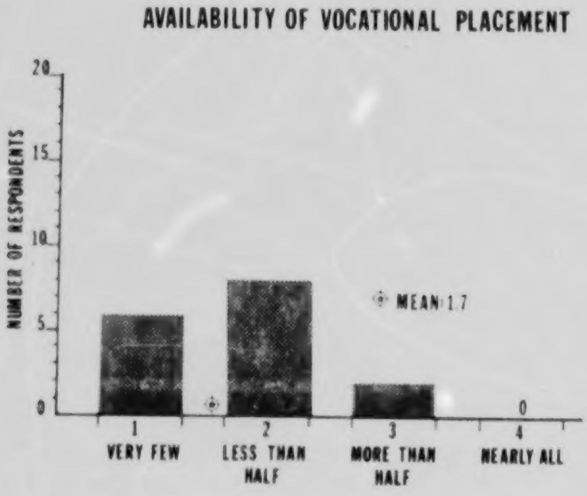


Figure 5 indicates that half of the respondents believe that placement services are available for less than half of the developmentally disabled population that needs them. Most of the remaining respondents believe that the service is available for very few in need.

Standards

The Employment Division Administrative Office has responsibility for enforcing standards of services in the employment offices. The standards are enforced through federal and state law, rules, and regulations. The programs are supervised by local office staff for operational purposes with specialists in the Administrative Office coordinating and controlling the content of the programs among state and federal offices concerned. The content of the laws, rules and regulations were not provided by the Employment Division.

The Vocational Rehabilitation Division utilizes and enforces standards for placement services as described in Section 10.1 (Standards).

8.4 SHELTERED EMPLOYMENT

Sheltered employment is a facility service which places primary emphasis on providing remunerative employment for an indefinite period of time for those individuals who are unable to meet the standards of the competitive labor market. Rehabilitation services play an important role to successful employment in the facility. Some individuals may develop sufficient productive skills to enable them to move to competitive jobs, although this is not a goal of sheltered employment. Staff should review the needs of each client to avoid "dead-ending" the client in a sheltered situation.

Facilities

The twenty facilities described on the map in Section 10.1 provide sheltered employment under a purchase of service agreement with the Vocational Rehabilitation Division.

Clients

During the period from July 1, 1973 to December 31, 1973, 47 individuals were receiving sheltered employment through the 20 facilities. Table 11 in the appendix describes the clients served by age and disability. Table 5, following, shows the distribution of clients served over the Mental Health Regions, and the relationship of those figures to total served and the total populations of the regions and the state.

TABLE 5

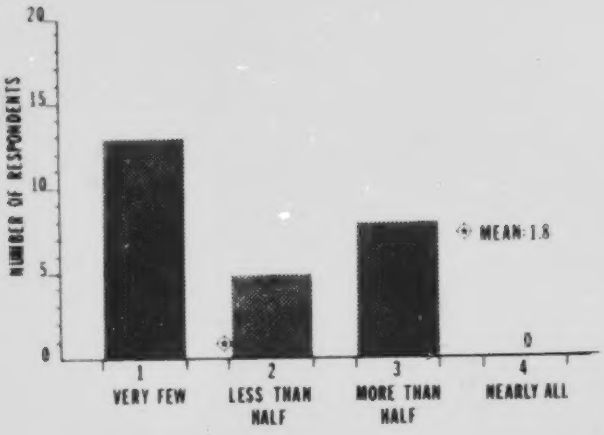
DVR CLIENTS IN SHELTERED EMPLOYMENT
JULY 1, 1973 TO DECEMBER 31, 1973

	Number Served	% of Total Served	Population in Region	% of Total Population
Region 1	15	31.9	909,465	43.5
Region 2	30	63.8	1,015,037	48.5
Region 3	2	4.3	166,875	8.0
TOTAL STATE	47	100.0%	2,091,377	100.0%

Table 5 indicates that, relative to population distribution, Mental Health Region 2 has a disproportionately high share of sheltered employment services while Regions 1 and 3 show a disproportionately low share.

The perceived availability of sheltered employment is shown in the following graph.

Figure 6



AVAILABILITY OF SHELTERED EMPLOYMENT

As indicated in Figure 6, half of the respondents believe that sheltered employment is available for very few of those who need it.

Standards

Standards for sheltered employment facilities, staffing, programming, administration and records and reporting are included in the document described in Section 10.1 (Standards). The standards are fairly complete in establishing criteria for each aspect of the operation. The section on Organization and Administration lays out standards for bidding and executing contracts and compliance with wage and hour regulations, for example, with references to client-related goals. The standards are enforced through on-site visits either annually or every three years, as described in section 10.1.

8.5 ACTIVITY CENTERS

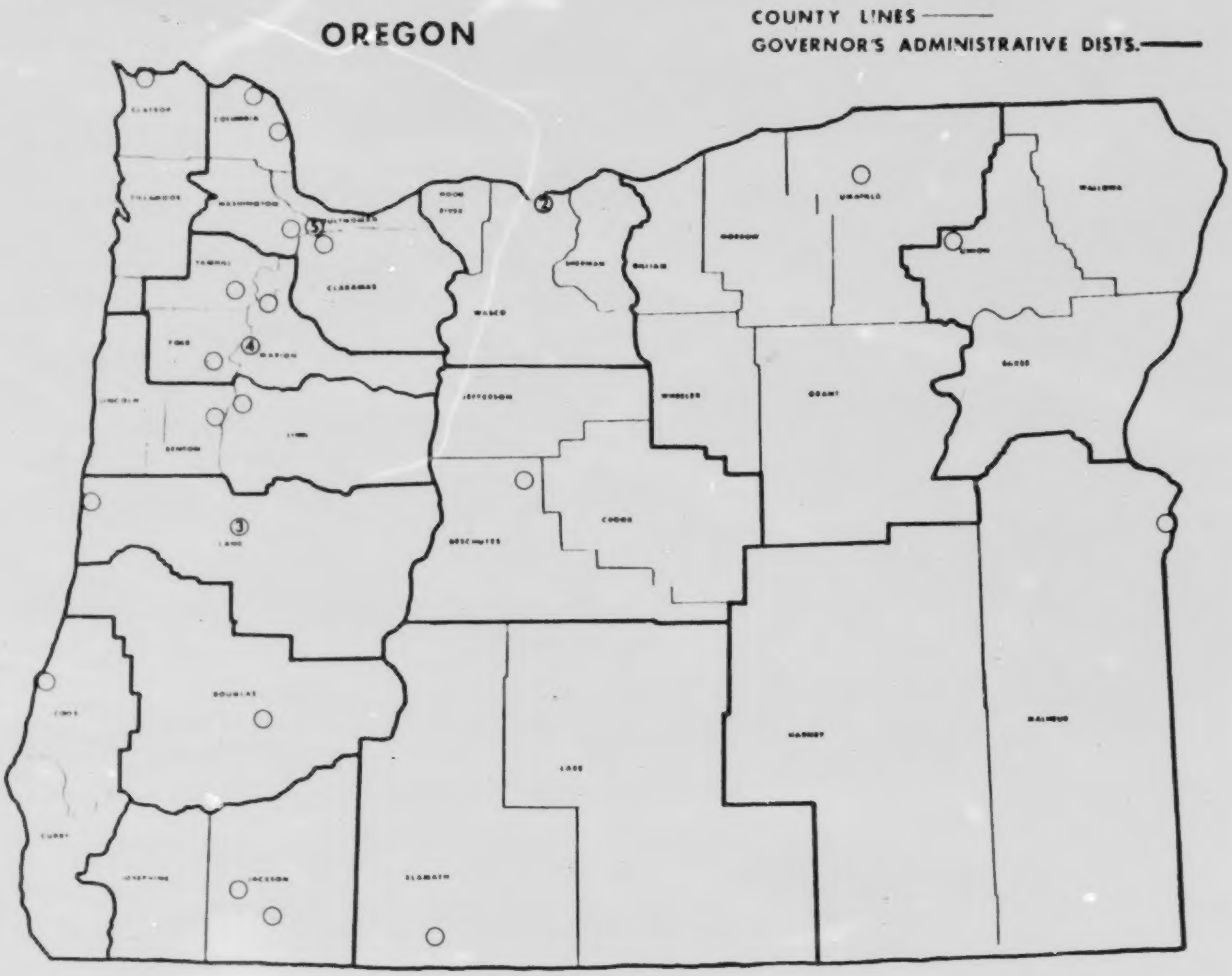
The Activity Center program is designed to provide the developmentally disabled adult with an away from home program. It shares responsibility with group home programs for providing "normalizing" activities and experiences. The programs are monitored by the Programs for Mental Retardation and Developmental Disabilities of the Mental Health Division.

Facilities

The activity center program in Oregon is one of the most rapidly expanding community programs designed to serve developmentally disabled adults. Since August 1973, there have been five Activity Center programs initiated and others are in stages of planning. At the time data were provided by Mental Health Division, 34 centers were operating in twenty counties. The map on the following page shows the locations of the centers.

FIGURE 7

LOCATIONS OF ACTIVITY CENTERS


OREGON
COUNTY LINES
GOVERNOR'S ADMINISTRATIVE DISTS.
CLATSOP
COLUMBIA
TILLAMOOK
WASHINGTON
MULTNOMAH
HOOD RIVER
②
WASCO
SHERMAN
GILLIAM
MORROW
UMATILLA
UNION
WALLOWA
YAMHILL
CLACKAMAS
⑤
POLK
④
MARION
LINCOLN
BENTON
LINN
JEFFERSON
WHEELER
GRANT
BAKER
③
LANE
DESCHUTES
CROOK
DOUGLAS
COOS
CURRY
JOSEPHINE
JACKSON
KLAMATH
LAKE
HARNEY
MALHEUR

Clients

Between July 1, 1973 and December 31, 1973, 557 clients were involved in activity center programs. Table 12 in the appendix describes the client characteristics by age and disability. Table 6, following, shows the distribution of clients across the Mental Health Division Regions and the relationship of those figures to the total population of the regions and the state.

TABLE 6

CLIENTS IN ACTIVITY CENTERS
JULY 1, 1973 TO DECEMBER 31, 1973

	Number Served	% of Total Served	Population in Region	% of Total Population
Region 1	146	26.2	909,465	43.5
Region 2	371	66.6	1,015,037	48.5
Region 3	40	7.2	166,875	8.0
TOTAL STATE	557	100.0%	2,091,377	100.0%

Table 6 indicates that, relative to population distribution, Region 2 has very high disproportionate share of activity center services. Region 1 is significantly low, while Region 3 is somewhat low.

The perceived availability of activity centers for developmentally disabled people is shown in Figure 8, below.

Figure 8

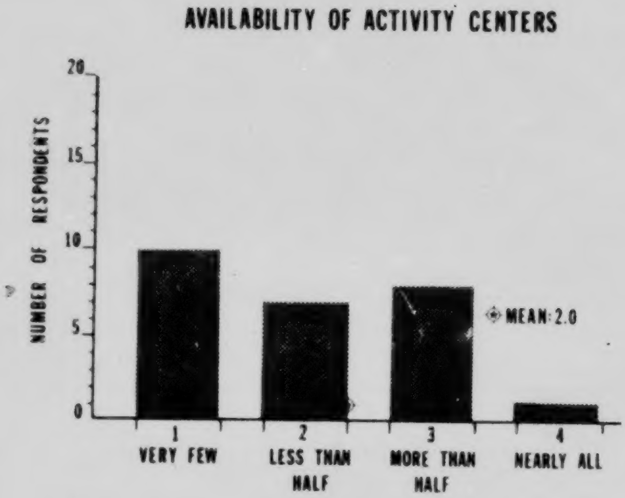


Figure 8 indicates that many of the respondents believe that activity centers are available to very few of those in need. The frequency of responses in columns two and three are almost as high as in column one demonstrating a spread of responses that may be due to geographic differences.

Standards

Staff and Facility Standards for activity centers have been developed by the Mental Health Division. They were just being put into final Administrative Rule form when data were provided by the Division. As they appeared in draft form, the standards established criteria for administration, client/staff ratio, record keeping, program (client) evaluation, community involvement, and facilities.

For evaluating program effectiveness in terms of client outcomes, an Adult Program Record has been developed cooperatively with activity center directors, staff and Mental Health Division. The Adult Program Record is a report of each individual's current functional level in several skills areas (work skills, social skills, and recreation). An Activities Record has been developed for use in conjunction with the Adult Progress Record; together they offer a comprehensive look at the programs, activities, and delivery system of community based services.

The Adult Progress Record and Activities Record have been implemented in the activity centers. The Administrative Rules for Staff and Facility Standards should be released for consumer review during May.

APPENDIX

TABLE 7

DVR CLIENTS RECEIVING VOCATIONAL EVALUATION
JULY 1, 1973 TO DEC. 31, 1973

	MR	CP	E	Multiply Handicapped	Total
7-19 years	507	29	18	6	360
20-44 years	1043	100	215	28	1386
45 + years	41	8	21	0	70
TOTAL	1588	137	254	34	2016

TABLE 8

DVR CLIENTS RECEIVING TRAINING
JULY 1, 1973 TO DEC. 31, 1973

7-19 years	117	6	3	0	126
20-44 years	315	21	48	8 (MR & E)	392
45 + years	11	2	5	0	18
TOTAL	443	29	56	8	536

TABLE 9

OED CLIENTS RECEIVING PLACEMENT
JULY 1, 1973 TO DEC. 31, 1973

16 + years	172	8	25	5	210

TABLE 10

DVR CLIENTS RECEIVING PLACEMENT
JULY 1, 1973 TO DEC. 31, 1973

	MR	CP	E	Multiply Handicapped	Total
7-19 years	23	0	0	0	23
20-44 years	120	10	23	3	156
45 + years	3	1	4	0	8
TOTAL	146	11	27	3	187

TABLE 11

DVR CLIENTS IN SHELTERED EMPLOYMENT
JULY 1, 1973 TO DEC. 31, 1973

7-19 years	1	0	0	0	1
20-44 years	39	0	2	0	41
45 + years	3	1	1	0	5
TOTAL	42	1	3	0	47

TABLE 12

CLIENTS IN ACTIVITY CENTERS
JULY 1, 1973 TO DEC. 31, 1973

18-44 years	389	19	12	70	490
45 + years	58	1	1	7	67
TOTAL	447	20	13	77	557

9.0 RECREATIONAL SERVICES

The discrete services in this cluster refer both to the therapeutic use of recreation and to the use of recreation for filling leisure time. In the latter sense, recreational activities can be planned or spontaneous, organized or unorganized, carried on alone or with others. This variability in function should be retained in recreational services.

9.0 RECREATIONAL SERVICES

Recreational services include the following types of programs:

> Therapeutic Recreation: Purposeful intervention through recreational activities to modify, ameliorate, or reinforce specific physical, emotional, or social behaviors.
>
> Leisure Time Recreation: The provision of ongoing programs and activities for the recreational use of leisure time. The choices of recreational activities should be of sufficient variety to permit individualized selection based on mental, physical, and emotional capacities, as well as urges of the moment. The various activities should provide outlets for physical interests (e.g., athletics), communicative interests (e.g., group discussions, writing), information interests (e.g., study group), creative and aesthetic interests (e.g., hobbies), and social interests (e.g., parties). Programs may include the teaching of skills related to the recreational activity selected.

At this time recreational programs for developmentally disabled people in Oregon are not an organized part of the service delivery systems. Where regularly scheduled programs are available, they have been initiated by local interest, have limited financial support, and serve only a small part of the population which needs this service. This is especially true in the area of adult recreation. While handicapped children have received the attention of generic recreational programs in many areas (Scouting and summer camp programs, for example), developmentally disabled adults have not been the focus of particular attention in the extension of community recreation.

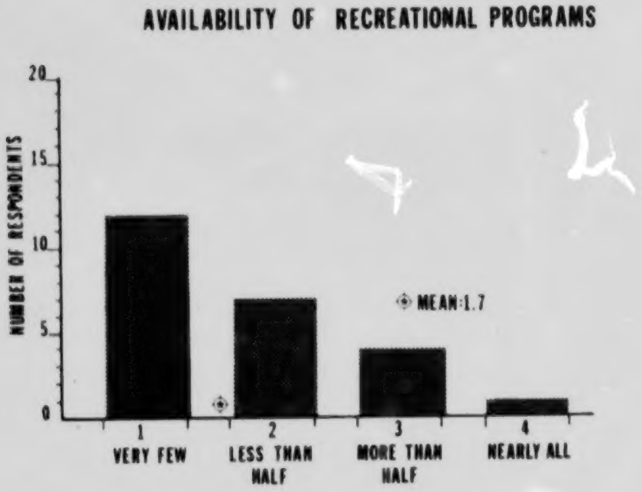
It is not possible to assess the quantity, quality, or effectiveness of recreational programs through state agencies since no agency has responsibility for the provision of this service to the developmentally disabled population.

In gathering data for this report, a questionnaire was sent to service coordinators and directors of Community Mental Health Programs asking them to assess, from their own experiences and perceptions, the extent to which services are available in their communities to developmentally disabled clients who need them. Each direct service that has been defined was rated on the following scale:

1 -- available for very few who need it
2 -- available for less than half who need it
3 -- available for more than half who need it
4 -- available for nearly all who need it.

The following graph (Figure 1) shows the mean scores of the respondents for one of the services included in this cluster.

Figure 1



As Figure 1 shows, the respondents believe that recreational services are available to less than half of those who need them.

9.1 THERAPEUTIC RECREATION

No data were collected regarding this service.

9.2 LEISURE TIME RECREATION

Leisure time recreation activities are usually included in the programs provided by group homes, activity centers, and classroom programs. In these settings it may be an important part of the program; but it is not, at this time, monitored as a discrete service. Consequently no data are available from those programs.

Data on recreational services were sought from state agencies in an effort to ascertain the mechanisms by which recreational programs for developmentally disabled people might be brought into the service delivery system.

Facilities

The State Parks and Recreation Branch of the Oregon State Highway Division recognizes the importance of communication and coordination in the rapidly expanding field of recreational programs. They have compiled a Park and Recreation Directory for Oregon which is updated regularly and identifies agencies and administrating personnel. The Parks and Recreation Branch does not at this time identify local agencies which incorporate programs for developmentally disabled children or adults.

Clients

At this time no agency is able to provide data as to the number of clients participating in recreational programs.

Standards

There are currently no standards regarding recreational programs for the developmentally disabled. Where recreation is a program element within another service (activity center, group home, or school program, for example), criteria for recreation may exist.

Statement of Progress

It is not possible to compare the status of adult recreation now with the baseline information. At both points in time data on the provision of the service were unavailable.

APPENDIX C

PRIORITIZED OBJECTIVES

The members of the three task forces generated well over 100 specific objectives. Only some of these objectives could be adopted for implementation. The Council's task, therefore, was to select those objectives of greatest importance, and then devote sufficient resources to task forces and committees for the implementation of high priority objectives.

The methods used to select and prioritize objectives are discussed in the body of this paper. Contained in the following pages are the outcomes of the Council efforts during the two-day workshop held in June, 1974.

Objective Directed to the Council

Objective: The State Developmental Disabilities Council should clearly define "developmental disabilities."

Rationale: The Developmental Disabilities definition is still somewhat unclear. A specific definition of the developmentally disabled should be clarified so that it might be possible to determine the numbers of those people that need to be served within the state.

General Support Services
Task Force Objectives

Priority

1 Objective: Developmental Disabilities Council will work with the Mental Health Division to achieve funding of service coordination programs in each Community Mental Health Program by 1977.

Rationale: Sixteen service coordinators are currently serving clients in twenty counties. The program has been implementing the following tasks for three years: registering developmentally disabled clients who are in need of services, documenting services that are available in the county served, matching clients with services, identifying unmet client needs, and helping to develop new services. We prefer that these services be available in all communities.

2 Objective: Developmental Disabilities Coalition (Oregon Association for Retarded Citizens, United Cerebral Palsy, Epilepsy League) should retain a lawyer this year to assist in the implementation of direct legal services to developmentally disabled clients, utilizing and educating the existing legal aid programs statewide by 1976.

Rationale: The personal and legal rights of developmentally disabled clients have received the attention of legislators and consumer groups. Those rights have been delineated. At the present time, however, there is no accessible, effective legal advocacy program knowledgeable about the needs of developmentally disabled individuals which offers direct services to developmentally disabled clients in regards to preserving their rights. We prefer that such a program be implemented by the consumer groups.

3 Objective: Mental Health Division should develop and implement an in-service education program for directors of Community Mental Health Programs regarding the needs of developmentally disabled people in order to assist them in planning for that population.

Rationale: Within the last year, directors of Community Mental Health Programs have been given the responsibility of planning for the delivery of services to developmentally disabled people. Formerly, their primary concern was with the mentally and emotionally disturbed. The needs of these populations differ in many ways. We recommend that those who are responsible for planning for developmentally disabled people be included in a program which will increase their awareness of the characteristics and needs of developmentally disabled individuals and the ways in which services can most usefully be provided to them.

4 Objective: This year the Mental Health Division should develop a public information program which would publicize the services that are available through the service coordinators. The program should reach individuals as well as public and private agencies.

Rationale: It appears that in the twenty counties where service coordinators are operating, a small proportion of the developmentally disabled population is aware of the program. Perhaps as little as 30 percent of the eligible population has actually made use of the service. Repeated reports from service coordinators indicate that some agencies in those counties are also unaware of the presence of service coordinators. Coordination cannot be effective under these circumstances. We prefer that the existence of service coordinators and the assistance they can offer be well publicized. The publicity should be directed toward potential clients as well as all the public and private agencies that relate directly or indirectly to the developmentally disabled population.

5 Objective: The Mental Health Division should develop a statement of minimum qualification for service coordinators this year. Funding of service coordinator positions within Community Mental Health programs should be contingent upon compliance with these minimum qualifications.

Rationale: During the initial implementation of the service coordination program, minimum qualifications for service coordinators were not described. Individuals have been hired on a subjective basis without uniformity across the total program. There have been no specific guidelines regarding the types of education and experiences that are relevant to the position. We prefer that there be a statement of minimum qualifications which would be applied throughout the state.

6 Objective: Mental Health Division should accept budgetary responsibility for secretarial assistance assigned specifically to each service coordinator.

Rationale: Service coordinators must provide many services to many clients. Without exception, they lack adequate clerical assistance. As the roles have developed and more clients are being served, administrative responsibilities have become increasingly burdensome. We strongly prefer that assistance be made available to all service coordinators through the assignment of sufficient secretarial help. The purposes of this recommendation are to relieve the coordinators of clerical office work; to improve the maintenance of related records; and to free service coordinators for continuing and expanding their provision of services to clients.

General Support Services

Task Force Objectives

Priority	Mean	Frequency					Reordered
		4	3	2	1	0	
1	3.24	11	6	3	0	1	
2	2.62	6	6	5	3	1	X
3	3.00	7	9	3	2	0	
4	2.90	7	6	7	1	0	
5	2.81	7	6	6	1	1	
6	2.71	6	6	7	3	1	

Identification and Assessment
Task Force Objectives

Priority

1 Objective: The State Health Division should expand the provision of Well Baby Clinics into those counties that do not yet have them.

Rationale: Well Baby Clinics provide needed screening opportunities in ten counties. Screening during infancy for developmental disabilities is critical because early intervention is a major influence on successful treatment. We prefer that screening as it is provided through Well Baby Clinics be available in all areas of the state.

2 Objective: Next year the Public Welfare Division should present a plan to the State Developmental Disabilities Council as to how they will document the impact and benefits of Medicheck during FY 75-76, including the extent to which developmentally disabled individuals have participated.

Rationale: Public Welfare Division has no information on the extent to which developmentally disabled individuals have participated in Medicheck. There is now no way of assessing the extent to which Medicheck provides unique services or duplicates existing services. We prefer that this information be available in order to evaluate the impact of Medicheck on developmentally disabled people.

3 Objective: During the next year the Social Security Office should develop a plan and implement a more aggressive outreach program for children who might be eligible for SSI benefits.

Rationale: Many developmentally disabled individuals who may be eligible for SSI benefits are unaware of the availability of such a program. We prefer that the Social Security office assume responsibility for publicizing the program and seeking out people who may be eligible. An out-reach program should especially speak to the benefits available to children and should clearly describe the conditions under which individuals qualify for benefits.

4 Objective: During the next year Children's Services Division should develop an active out-reach program for Medicheck, for the purpose of informing eligible clients about Medicheck services. Assigning at least one full-time staff position in each office to that program is recommended as a possible procedure for implementing that program.

Priority

4 Rationale: Many children eligible for Medicheck are not being screened; we preferred that all eligible children be served. Many of those not being screened are clients of Children's Services Division; Children's Services Division does not now have manpower to implement the Medicheck program; we believe that the allocation of one person in each office would assist measurably in finding those children who are eligible and assuring that they receive Medicheck services.

5 Objective: Child Development Clinics and Crippled Children's Division should establish at least one facility and/or frequent and regularly scheduled satellite clinics in Mental Health Region 3 during the next year.

Rationale: All diagnosis and evaluation clinics established through Crippled Children's Division and the Child Development Clinics are located in the western part of the state. Clients residing in Mental Health Region 3 who need these services must travel long distances or depend on occasionally scheduled satellite clinics. We prefer that residents of Eastern Oregon have available in closer proximity to their homes, regular on-going diagnosis and evaluation clinics such as those now serving Regions 1 and 2.

6. Objective: Periodic check-points for re-screening should be implemented through schools, public health nurses, and/or Medicheck to identify disabilities which may have developed since previous screenings or may have been overlooked previously. The Health Division, Public Welfare Division and Department of Education should work together this year to develop plans for implementing this program next year.

Rationale: There are on-going screening programs within the state which attempt to identify individuals who may have a developmental disability. These screening programs may fail to identify signs of delay or deviance in some individuals. Moreover, indications of development delay or disability may not yet be apparent at the time an individual passes through the broad screening programs. We prefer that programs be established for re-screening at periodic intervals for the purpose of identifying individuals whose indications of disability emerged later in his life. We prefer that re-screening programs be implemented through agencies that reach the broadest possible population.

Identification and Assessment

Task Force Objectives

		Frequency				
Priority	Mean	4	3	2	1	0
1	3.57	14	6		1	
2	3.14	10	6	4		1
3	3.14	9	8	2	2	
4	3.10	8	8	4	1	
5	3.00	9	6	3	3	
6	2.95	6	9	5	1	

Treatment
Task Force Objectives

Priority

1 Objective: Crippled Children's Division should expand the development of outreach treatment (P.T., O.T., S.T.) programs for developmentally disabled children. The treatment programs should be community based (i.e., home, school, activity centers, nursing homes, etc.) and should provide service over a broader geographic area. Funds for three teams should be made available during the next year.

Rationale: Physical therapy, occupational therapy, and speech therapy are available through the state on a regular basis only for those children who live within accessible distance of major clinics (Portland, Eugene and Medford). Treatment is very limited for children in other communities. We prefer that a plan be developed and implemented for outreach treatment teams to serve children over a broader geographic area.

Treatment

Task Force Objectives

		Frequency				
Priority	Mean	4	3	2	1	0
1	3.33	11	7	2	1	

Educational Services
Task Force Objectives

Priority

1 Objective: Within the next year Mental Health Division with the cooperation of the State Department of Education, Crippled Children's Division and other appropriate agencies should complete the development of standards for the preschool education of developmentally disabled children and plan for the extension of preschool services to all developmentally disabled children in the state. Expansion of services should utilize: integrated facilities where appropriate, the Head Start programs, day care centers, home training, and/or public schools.

Rationale: The Mental Health Division is currently preparing standards for preschool education of developmentally disabled children. The new standards for preschool education should be broad enough so that they will cover both special programs for developmentally disabled children as well as Head Start and other generic programs for preschoolers. It has been amply demonstrated at this point in time that preschool education is of prime benefit to the developmentally disabled. Preschool education should encompass ages 0-6, and plans should be developed to service all preschool developmentally disabled children in the state incorporating utilization of any model that will provide this preschool education in consonance with the development of preschool standards.

2 Objective: Mental Health Division and Oregon Board of Education should complete the development of a state-wide evaluation system capable of monitoring all educational services to developmentally disabled people at the program level, utilizing individual pupil outcomes to assess program effectiveness. The system should be developed this year for implementation during FY 75-76.

Rationale: A statewide evaluation system has already been established for the trainable mentally retarded populations and for those receiving Title VI services who are also developmentally disabled. We recommend that a statewide system be developed for all developmentally disabled which will allow agencies such as the Developmental Disabilities Council in addition to the Mental Health Division and the Oregon Board of Education to monitor the progress of programs. The statewide evaluation system should provide a means for the local programs to monitor their effectiveness. The evaluation system should also provide information for program and training decisions at the state level.

Priority

3 Objective: Oregon Board of Education should complete the development of standards for the publicly supported education of developmentally disabled students under its jurisdiction within the next year.

Rationale: The Oregon Board of Education is currently preparing standards for the educable mentally retarded population; these standards should be completed shortly and applied to all educably mentally retarded populations in the State whether they be served in special classes, resource classes, or in the mainstream of education.

4 Objective: Children's Services Division with cooperation of Mental Health Division should develop a plan for providing quality education within day care programs for eligible developmentally disabled pre-school children, to be implemented during FY 75-76.

Rationale: It is difficult at this time to sort the responsibilities of Children's Services Division and Mental Health Division. Those who are in the business of providing services to developmentally disabled children often find themselves caught between the two agencies. We prefer that Children's Services Division become involved in preschool education and develop plans in cooperation with the Mental Health Division for providing day care to those children who become eligible under Children's Services Division regulations.

5 Objective: Head Start and other federally funded pre-school programs in cooperation with Children's Services Division and the Mental Health Division should develop a plan for providing quality integrated programs to eligible developmentally disabled children, to be implemented in FY 75-76.

Rationale: Head Start is now required to guarantee that 10 percent of the children served in their programs are handicapped. Unless these efforts are coordinated with those of the Children's Services Division and Mental Health Division, services are likely to develop in a haphazard manner. We prefer that a coordinated plan for provision of services be used.

6 Objective: The Oregon Board of Education should develop a mechanism for coordinating and disseminating information about the educational services available through the Regional Resource Center, the Area Learning Resource Center, the Learning Disabilities Center, and other state-wide resource agencies.

Priority

6 Rationale: There are at the present time a number of agencies in the state not associated with the Oregon Board of Education who are providing educational services. These include the ones listed above and may also encompass other agencies not so listed. This objective suggests that the Oregon Board of Education will provide information to all concerned about them. It also requests that the Oregon Board of Education adopt the role of coordinating the various educational services being provided in the state.

Educational Service

Task Force Objectives

Priority	Mean	Frequency 4	3	2	1	0	Reordered
1	3.10	13	4		1	3	X
2	3.14	11	5	3	1	1	
3	3.11	10	5	2		2	
4	3.10	11	3	6		1	
5	2.95	10	3	6	1	1	
6	2.76	7	4	8	2		

Family Support Services
Task Force Objectives

Priority

1 Objective: The Mental Health Division, Crippled Children's Division and the Oregon Board of Education should take strong positions on the need for cooperative home-school family training programs for families of developmentally disabled children. Guidelines for such programs should be developed jointly by the two agencies during the next year.

Rationale: Based on the philosophy that there are certain subjects being taught in programs for the developmentally disabled which can best be taught in the home as a supplement to the school environment, such as language, self-help skills, basic motor tasks, and the remediation of inappropriate behaviors, we recommend that the Oregon Board of Education and the Mental Health Division should develop guidelines to illustrate how such joint training can take place and how teachers can assist and monitor parents' conduct of such training.

2 Objective: Children's Services Division should actively sponsor in conjunction with Mental Health Division a training program for foster parents and siblings in regards to the placement of developmentally disabled children in their homes. Plans for such a training program should be developed this year for implementation by FY 76.

Rationale: One of the major problems in the placement of a handicapped child with foster parents is that many foster parents, although willing to take a handicapped child, feel they do not have the necessary skills to cope with the child's needs. Moreover, they believe their caring for a handicapped child may require considerably more effort and energy on their part than caring for a normal child. If foster parents could be trained systematically and routinely with the opportunity for follow-up consultation, more foster parents would be willing to take developmentally disabled children and thus more could be placed in foster homes. Since Children's Services Division has primary responsibility for foster home placement, it is recommended that they sponsor in conjunction with the Mental Health Division a plan for the training of foster parents.

3 Objective: The Mental Health Division should take a strong position on the need for training of living unit parents in cooperation with and supportive to the school programs for institutionalized children. A plan for living unit parent training should be developed this year, to be implemented by FY 76.

Priority

3 Rationale: In the same sense that it is desirable for parents of handicapped children in community settings to be involved in the training of their handicapped children, especially in the areas of self-help skills, language, and basic motor skills, it is also logical that living unit parents should be involved in the training of developmentally disabled people in an institution. This concept is not now widely practiced among institutional populations. Therefore, it is recommended that the Mental Health Division develop such a plan for training and implementation.

4 Objective: The Mental Health Division should continue the development of guidelines and standards for emergency and scheduled short-term respite care provided by the State Hospital and Training Centers. The standards should be completed this year for implementation by FY 76.

The Mental Health Division should publicize the availability of respite care services through the State Hospital and Training Centers and the Community Mental Health Programs. A plan for such an information program should be developed and implemented during this fiscal year.

Rationale: At the present time no guidelines or standards for emergency or scheduled short-term respite care in the State Hospital and Training Centers have been adopted. Standards and guidelines must be adopted and implemented in order to assure the provision of quality care. We recommend that the Mental Health Division complete the development and eventually adopt and implement guidelines and standards.

Over-night respite care services have been available for a year through the State Hospital and Training Center. During that time, 1 (one) person made use of the service. Emergency and, occasionally, scheduled over-night respite care are available in local major medical facilities through the Community Mental Health Programs. These opportunities were also underutilized during the last year. The underutilization of these services may reflect the consumers' unawareness of the service. We recommend that the Mental Health Division provide the needed information to the consumers.

Priority

5 Objective: The Mental Health Division should fund a sufficient number of parent training specialists within the next year to ensure full geographic coverage of the state maintaining the same quality of service that is now being provided in the program.

Rationale: Parent training specialists are now provided with a core clinic in Monmouth and satellite clinics in La Grande, Bend, Portland, Salem, Eugene, Grants Pass and Medford. Each of these parent training specialists have the responsibility of providing service to the county in which they are located. Coverage is therefore only provided for a small number of counties in the state and needs to be extended so that parents and other counties can receive the same type of service.

6 Objective: Mental Health Division should continue to conduct or contract for the evaluation of all existing parent training specialists. Both the Mental Health Division and the Oregon Board of Education should monitor the number of cooperative home-school programs implemented through the parent training program during the year.

Rationale: Since the concept of parent training specialist is a relatively new one, their effectiveness should be evaluated by a third party evaluation specialist who is neither associated with the parent training specialist, Teaching Research, the Oregon Board of Education, or the Mental Health Division. If monies are not available for a third party evaluation, then the Oregon Board of Education and the Mental Health Division should themselves undertake such an evaluation.

7 Objective: The Mental Health Division, Health Division, and Crippled Children's Division should expand the role of the parent training specialists to include the provision of instruction and training regarding sexuality and community adjustment of developmentally disabled adolescents and adults.

Rationale: The parent training specialists now focus more exclusively on school age populations or preschool populations. There is a need for the training of parents of adolescents and adults in aspects of sexuality, and it is believed that the parent training specialists might take on this role and provide a resource within the community for parents of adults and adolescents.

Priority

Rejected Objective: The Oregon Health Division should require in its licensing standards for group homes that each facility have space available for out-of-home respite care.

Rationale: There are very few provisions in the community for out-of-home respite care. The need for this service is not great enough or steady enough to support an agency which provides only out-of-home respite care. We prefer that every community group home have a bed available for over-night respite care. To assure that such space is made available, we recommend that the Oregon Health Division require it in its licensing standards for group homes.

Rejected Objective: The Children's Services Division and Public Welfare Division should certify that facilities which provide out-of-home respite care (short-term residential care) are meeting prescribed standards for physical facility, staffing, and programming.

Rationale: No state agency currently has responsibility for the certification of facilities providing out-of-home respite care in the community. To assure quality of care, facilities need to be certified as to physical facility, staffing, and programming. The service is purchased on a client-by-client basis through Children's Services Division and Public Welfare Division. We recommend that those agencies be responsible for certification of those facilities from which they purchase services.

Family Support Services

Task Force Objectives

Priority	Mean	Frequency 4	3	2	1	0	Reordered
1	3.38	9	11	1			
2	3.19	12	4	3	1	1	
3	3.19	10	6	4	1		
4*	3.14	9	7	4	1		X
	2.86	7	7	5	1	1	
5	3.05	9	7	3	1	1	
6	3.00	9	6	4	1	1	
7	2.95	11	5	1	1	3	
Rejected		1			3	17	
Rejected		2	2	2	2	13	

*Two recommended objectives combined.

Living Arrangements
Task Force Objectives

Priority

1 Objective: The Mental Health Division and other appropriate agencies, specifically the Division of Vocational Rehabilitation, should assure that start up costs are available for new facilities offering group home care in areas which evidence at least a minimum degree of out-of-facility support services. Other agencies that provide supportive services should cooperate with the Mental Health Division in assuring financial support for out-of-home services. At least 30 new facilities with an average of 10 people per facility should be operational by the end of the 1975-77 biennium.

Rationale: At the present time we believe that the need far exceeds the 300 clients recommended to be provided services in this objective. To establish new group care facilities in the community, a certain level of out-of-facility support is needed (i.e., day programs, recreation, and transportation). Many new facilities with varying levels of supervision and adequate community support services will need to be established. We recommend that Mental Health Division and Division of Vocational Rehabilitation plan for and subsidize the start-up of needed facilities.

2 Objective: The Public Welfare Division, Children's Services Division, Mental Health Division, and the Health Division should complete the development of a new schedule for purchasing services for clients who need group care, based on a careful analysis of cost for services. The schedule should enable the Divisions to purchase services at a higher level of care reflective of the increasingly higher standards.

Rationale: As standards for care in group residential facilities improve, the cost for services will increase. The assistance available through Public Welfare Division and the other agencies is not adequate to cover the increased cost of services in the facilities offering a higher level of care. A new schedule of payment needs to be applied--one which assures that payments will be commensurate with services rendered.

3 Objective: By July, 1977, the Mental Health Division should assure the provision of funding for program directors in at least 50 group care facilities with the purpose of bringing the level of service in those facilities up to the minimum requirements for licensure.

Priority

3 Rationale: Many existing group care facilities currently do not meet the staffing requirements being proposed in the draft regulations for Group Care Home Rules. If and when the rules are adopted and implemented, these facilities may lose existing sources of funds if they fail to qualify for licensure. This may force the closure of many facilities and the consequential return of clients to institutions. We prefer that program directors be placed in the facilities so that they will come into compliance with standards and upgrade the quality and effectiveness of programs for their clients.

4 Objective: Those agencies responsible for developing standards for group care should attend to the following considerations:

a. standards should be developed in conjunction with national standards;
b. standards should include provisional measures for the gradual upgrading of care in existing facilities;
c. cost and client effectiveness impact statements should be prepared;
d. compatibility with concept normalization.

Rationale: The establishment and implementation of new group care standards will have immediate and significant impact on the provision of services. The immediate effect is not always one which benefits the client. Standards which require significantly higher quality (and cost) of service than is currently being provided in operating facilities may force sudden closure of facilities if provisions are not made for gradual up-grading of service. Standards developed in isolation may conflict with already existing standards. We prefer that certain steps be taken during the development of standards that will allow for smooth implementation that is beneficial rather than detrimental to the clients who need services.

5 Objective: Community colleges with support and participation of University Affiliated Facilities should provide within their paraprofessional programs (such as the Human Resources Technician programs) a curriculum of training for those who may work with developmentally disabled people including training in: (1) administration of residential facilities and (2) residential program implementation.

Rationale: People who anticipate working with developmentally disabled clients in group care settings have little opportunity for formal study that will give them useful, applicable training. Currently some community colleges offer two year programs

Priority

5 for students who wish to pursue human services careers. We prefer that these programs be expanded to provide specific training in the administration and operation of programs for developmentally disabled people. Home providers are requesting such training for their own development. Curricula such as this recommendation suggests would allow for the placement of practicum aides in existing group homes, benefitting both the group home programs and the students.

6 Objective: Department of Human Resources should implement its commitment to the Senate Human Resources Committee by establishing a Community Facilities Committee involving representatives of various levels of government, state agencies, providers, and consumer groups for the purposes of: (1) reviewing all rules and regulations relating to community facilities, (2) assuring the coordination of rules, regulations, and funding at various levels of government, (3) assessing need for future legislation, and (4) making recommendations to the director of Human Resources, who in turn will direct a systematic coordinated approach to implement the recommendations through the appropriate divisions.

Rationale: Development and implementation of standards for community facilities will necessarily affect directly or indirectly many state and local agencies as well as providers and consumers of services. At the present time only few of those who will be affected are involved directly in the process. The resulting lack of coordination and communication leaves unattended conflicting goals and activities.

7 Objective: The Department of Education and Mental Health Division with the cooperation of other appropriate agencies should work with the existing group homes or encourage the development of new facilities to provide training for students while they are still in school in the community or in the institution.

Rationale: Residential training is a key still that developmentally disabled clients need to obtain in order to achieve the highest possible level of independence for living in the community. It should be closely tied to the educational services received.

Living Arrangements

Task Force Objectives

Priority	Mean	Frequency 4	3	2	1	0
1	3.85	17	3			
2	3.71	16	4	1		
3	3.48	15	3	1	2	
4	3.35	10	8	1	1	
5	3.14	10	6	3	2	
6	2.95	10	7		1	3
7	2.71	9	5	3		4

Vocational Services
Task Force Objectives

Priority

1 Objective: The Public Welfare Division should expand welfare subsidy payments for sheltered employment from the present level of 300 to 1000 by July 1977. Special consideration should be given to the profoundly and severely handicapped.

Rationale: The Public Welfare Division's subsidy program for sheltered employment has allowed workshops to assign stations for long-term employment of developmentally disabled people. This service would not have been available without the subsidy program because of the low operating capital the sheltered shops have available. The program has been only minimally applied, but the results of the program have shown significant benefit in giving employment to moderately and severely handicapped people and, in some cases, assisting those people to eventually move into competitive work. We prefer that the program be expanded to serve more developmentally disabled people.

2 Objective: The Vocational Rehabilitation Division should develop new workshops in Salem, Klamath Falls, and La Grande or Baker within the next year.

Rationale: There are areas of the state with documented need for sheltered training and employment that have no sheltered workshops. Without workshops many developmentally disabled people are completely isolated from meaningful work and work training experiences. We prefer to see the establishment of new workshops during the next year in communities that need them.

3 Objective: Vocational Rehabilitation Division should increase funding to allow for an expansion of workshop work/stations in existing facilities from 1400 to 3000 by July 1, 1977. Special attention should be given to the profoundly and severely handicapped.

Rationale: The number of sheltered work/stations for developmentally disabled people is inadequate to meet current need. The service is available to less than half the population in need of it. We prefer that the availability of the service be expanded by increasing the number of work/stations in existing facilities.

Priority

4 Objective: The Vocational Rehabilitation Division work-study contracts with public schools should be expanded with cooperation of the Oregon Board of Education to cover the districts not now covered.

Rationale: The Vocational Rehabilitation Division currently has work-study contracts with most of the school districts in the state. The program provides work training and experience for educable mentally retarded students. There are some parts of the state that do not have work-study contracts. There is a need for the same program for educable mentally retarded students in those areas as well. We prefer that all public schools have work-study contracts with the Vocational Rehabilitation Division.

5 Objective: The Vocational Rehabilitation Division and the Oregon Employment Division should develop by July 1977 at least 500 sheltered jobs within private industry. Appropriate agencies (Vocational Rehabilitation Division, Oregon Association for Retarded Citizens, and Public Welfare Division) should work together to develop subsidy and training programs as necessary (and work with individuals on job counseling).

Rationale: There are many developmentally disabled people who could work successfully in private industry if sheltered work-stations were established. This is a resource that has not been well developed in the past. We prefer that sheltered jobs be established in private industry and related training programs developed.

6 Objective: The Public Welfare Division in cooperation with the Mental Health Division should adjust payment procedures for activity centers to reflect the cost of services purchased rather than making payments on client tuition basis.

Rationale: The Public Welfare Division pays for eligible clients to receive activity center services on a tuition basis. Activity centers, however, are serving clients who demonstrate varying degrees of disability. Services are rendered to them on an individual program basis. Some clients need more services and/or more costly services than others. We prefer that the Public Welfare Division pay for the activity center services on a purchase-of-service basis, individualizing the payment process as the programming and training are individualized.

Priority

7 Objective: The Vocational Rehabilitation Division and Oregon Employment Division should assume responsibility for placement of more clients from workshops into the community, utilizing available subsidy funds such as the National Association for Retarded Citizens/On The Job Training. The agency should increase placement services from the present level of about 100 clients placed per year to 300 per year over the next year.

Rationale: Many clients who receive training through sheltered workshops and some of those who are placed in workshops for employment develop skills and behaviors that make them eligible for employment in the community. Placement services need to be provided at a higher level than they have been previously. As the number of work stations for training services increases, the need for placement services will also increase. We prefer that the Vocational Rehabilitation Division assume responsibility for the placement of more developmentally disabled people.

8 Objective: The Public Welfare Division in cooperation with the Vocational Rehabilitation Division would compute the amount paid for subsidized sheltered employment to reflect the cost of the level of service being offered.

Rationale: Workshops which have been participating in the employment subsidy program with Public Welfare Division have been providing increasingly higher levels of service. This results in an increase in cost. At the same time, the rates for payment under the subsidy program have not gone up. We prefer that the amount of the payments be increased to realistically reflect higher costs.

9 Objective: The Vocational Rehabilitation Division should improve training of facility personnel in the area of work evaluation and work adjustment training in at least 20 existing workshops during the next year.

Rationale: Client-supervisors are coming from non-relevant employment experiences without related training. The people working with clients must be capable of assessing client potential and be able to work with the client in a treatment plan.

10 Objective: The Vocational Rehabilitation Division in cooperation with the Mental Health Division should contract with program developers in the residential settings for the vocational development services they render including assessment, job development, training, placement, and follow-up.

Priority

10 Rationale: At the present time, a number of group homes employ program developers who render vocational services. They make individual vocational assessments, develop job opportunities, train residents in work skills and work adjustment skills, provide placement services for residents who are ready to move into jobs, and follow-up the placements of those clients. The program has worked successfully in the homes that have used it. The cost of the vocational development services, however, are not included per se in the cost-for-care payments. We prefer that Vocational Rehabilitation Division support the employment related services offered by the program developers.

Vocational Services

Task Force Objectives

Priority	Mean	Frequency				
		4	3	2	1	0
1	3.33	10	8	3		
2	3.20	11	4	4		
3	3.19	9	9	2		1
4	3.10	9	5	7		
5	3.05	8	7	5	1	
6	3.00	9	6	4	1	1
7	3.00	9	5	6		1
8	2.95	7	8	5		1
9	2.81	5	7	9		
10	2.75	7	4	7	1	1

Transportation Services
Task Force Objectives

Priority

1 Objective: State Department of Transportation should develop minimum standards for transportation needs of individuals with mobility problems that would be considered a part of any planning and development of mass transit (urban and rural) services in Oregon.

2 Objective: The State Department of Transportation, Regional Planning Bodies (i.e., Tri-Met, CRAIG . . .) should include representation of the DD population on these planning bodies in the development of future public transportation systems both special transportation systems and general mass transit systems.

3 Objective: All State agencies providing program services for developmentally disabled should include plans for transportation in their development of these services and consideration of funding for transportation as a part of the budgeting of these programs.

Transportation Services

Task Force Objectives

Priority	Mean	Frequency 4	3	2	1	0
1	3.86	18	9	0	0	0
2	3.67	15	5	1	0	0
3	3.57	15	5	0	0	1

Recreation Services
Task Force Objectives

Priority

1 Objective: The Parks and Recreation Branch should accept the responsibility for providing leadership in the development of recreational service to handicapped people throughout the state: i.e., developing guidelines and programs for handicapped people in both separate and integrated services. Plans for implementing this responsibility should be developed this year for implementation in FY 76.

Rationale: At this time, no single state agency has responsibility for developing, maintaining, or monitoring the delivery of recreational services to handicapped people. Consequently, the state as a whole lacks direction, coordination, or guidelines in that service area. We prefer that a single agency be responsible with the hope that the availability of services will be assured and the quantity and quality of services will be monitored. It is appropriate for the Parks and Recreation Branch to provide leadership in the development of recreational programs for mentally and physically handicapped people as they have for the elderly population.

2 Objective: Local recreational agencies should develop coordinated programs for handicapped people utilizing all community resources (YMCAs, Associations for Retarded Citizens, Bureau of Land Management, Forest Service, public agencies, etc.). This effort should be implemented in at least three communities this year, with other communities being included with all practical speed.

Rationale: Many local agencies provide a variety of recreational programs for handicapped people. The programs provided are usually irregular but occasionally on-going. They are not coordinated. We prefer that the local agencies continue to provide the services they have been offering. But we also recognize the need for coordination and the development of more on-going recreational programs. The placement of responsibility for recreation for the handicapped with a single state agency should not discourage the continuation of programs sponsored by private groups and other public agencies. Instead, the expansion of those programs should be facilitated by the responsible state agency.

3 Objective: This year the Department of Education and local recreation departments should develop plans for working through local community school programs to provide recreation for handicapped including developmentally disabled people on a 12-month basis in special as well as integrated programs. Plans should be implemented by January 1975.

Priority

3 Rationale: Many areas in the state, especially rural areas, are not included in local Parks and Recreational Districts. Should the Parks and Recreation Branch actively engage in developing programs for handicapped people, these areas would not be included. In order to utilize many potential resources and allow broader geographic coverage, community schools should also be encouraged to give attention to programs for mentally and physically handicapped people.

4 Objective: During the next year Parks and Recreation Branch of the State Highway Division should develop a directory of local recreational services that are available to developmentally disabled people, and the resulting directory should be appropriately disseminated. The local directories should be compiled into a state directory by the Parks and Recreation Branch.

Rationale: To gain information about local recreational services, an individual must go to many different sources. The sources of information are often difficult to identify. If recreational services are to be effectively utilized, information about them must be readily available through a single, accessible source. A directory of all local recreational services compiled locally and disseminated to service coordinators and other interested people would make needed information available to consumers.

5 Objective: Printed regional plans for recreational programs and evaluations of the programs should be provided by the Parks and Recreation districts to service coordinators, other involved agencies, and people. Plans should include goals and objectives of the programs as well as activities for carrying them out.

Rationale: Handicapped individuals or the parents of handicapped individuals and providers of services who are interested in recreational programs often want specific information about a program before they agree to participate. For example, they may want to know the goals of the program and the activities that are planned. Currently, the information is difficult to acquire. We prefer that this type of information be available in a printed plan, and that the plan be distributed to individuals and agencies which serve handicapped people.

6 Objective: The Parks and Recreation Branch should regularly, at least annually, convene a statewide meeting of regional recreational personnel for the purposes of coordinating, consulting, and planning for the development of services to mentally and physically handicapped people.

Priority

6 Rationale: Recreational services for handicapped people currently seem to be fragmented, weakly supported, uncoordinated, and limited in variety, location, and client capacity. At the same time there are individuals who have developed high quality recreational programs for mentally and physically handicapped people. Important resources, such as individual expertise and program plans, could be shared around the state by those who are trying to develop and/or maintain recreation services for handicapped people. Coordinating and consulting on a regular basis would encourage the expansion of high quality programs.

Recreation Services

Task Force Objectives

Priority	Mean	Frequency 4	3	2	1	0
1	3.38	12	5	4	0	0
2	3.38	9	11	1	0	0
3	3.29	11	5	5	0	0
4	3.10	9	6	5	1	0
5	3.00	8	6	4	2	0
6	2.86	9	3	6	3	0

Short-term Funding Objectives
Task Force Objectives

Priority

1 Objective: Funds should be allocated for a public education project directed toward increasing the awareness of state legislators, local public officials, potential consumers, and the public as a whole concerning the composition and the needs of the developmentally disabled population. The project should be planned and implemented this year.

Rationale: To the general public and to many public officials at local, county, and state levels, the needs of the developmentally disabled population do not exist because they lack awareness of these needs. Public awareness must occur before the community can be asked to assume its responsibility in reaching all its citizens, including developmentally disabled people.

2 Objective: Funds should be allocated for projects related to the vocational evaluation and training of severely handicapped people.

Rationale: Severely handicapped people have almost no opportunity for vocational training and productive employment. Demonstration projects have shown that severely handicapped individuals can be trained to do complex contract work at a high level of competence and productivity. We prefer that projects which offer these opportunities to severely handicapped clients be encouraged.

3 Objective: Funds should be allocated for pre-school programs for developmentally disabled children ages 0 to 6 years.

Rationale: Funds are needed for at least the start up of the preschool programs for developmentally disabled children. It is hoped that continued financial support would eventually be achieved through other agency sources.

4 Objective: Funds should be allocated for a pilot foster-parent training program.

Rationale: With the exception of two federally funded foster parent training programs, one in Portland and one at Teaching Research, both of which are just in their embryonic stages, little effort is being made throughout the state to train foster parents to handle developmentally disabled children. It

Priority

4 is therefore recommended that DDSA funds be allocated for such training. Training sites in other parts of the state, namely Southern Oregon and Eastern Oregon, will be needed.

5 Objective: Funds should be allocated for start up cost for new group homes and/or the hiring of group home directors to work in existing and new group home facilities.

Rationale: Group care homes are available for less than half of the developmentally disabled population who need them. It has been recommended that Mental Health Division take the lead responsibility during the 1975-77 biennium for establishing new facilities. However, the immediate need should be met through the use of short-term discretionary funds this year.

Many existing group care facilities currently do not meet the staffing requirements being proposed for the Group Care Home Rules. While it has been recommended that Mental Health Division allocate funds for the 1975-77 biennium to help these homes meet staffing requirements, short-term funding is necessary to facilitate immediate improvement in staffing and program implementation in existing group care homes.

6 Objective: Funds should be allocated for the development of community based outreach teams to provide treatment (Physical Therapist, Occupational Therapist, Speech Therapist) to physically handicapped developmentally disabled children. Funds for three teams should be made available during the next year.

Rationale: Therapy services for children are limited geographically. Only families which live near and can secure transportation to major clinics can participate in regular therapy programs. We prefer that teams be established in order to provide therapy programs to clients who do not now have access to existing clinics.

7 Objective: Funds should be provided for the development and implementation of training programs for teachers concerning appropriate and inappropriate identification of persons with possible developmental disabilities, and where to find appropriate resources for those in need of services.

Rationale: School classrooms provide an excellent opportunity for identifying children who may have a developmental delay or disability. At this time, however, most classroom teachers do not have the skills for making assessments of that type. We prefer that teachers be trained to appropriately identify possible developmental delays and disabilities.

Priority

8 Objective: Funds should be allocated to the development of evaluation systems based on client outcomes. The systems should be applicable to specific state-wide education programs.

Rationale: For the educational services available through state agencies, evaluation systems should be developed that will allow for statewide accountability and will also allow local school districts to receive information from the evaluation system that will help them to make pupil and program decisions. We prefer that funds be made available to assist the state agencies in the development of such systems.

9 Objective: Funds should be used to develop a pilot work evaluation center integrated with a sheltered workshop in those parts of the state where work evaluation centers are not now providing services.

Rationale: Work evaluation centers are established in the western metropolitan areas: Portland, Salem, and Medford. Individuals outside of those areas, especially in Mental Health Region 3, do not have thorough work evaluation services accessible to them. We prefer that alternative programs be developed that will allow the provision of work evaluation services in other parts of the state. Specifically, we suggest that, on a pilot basis, a sheltered workshop in an area not now served by existing work evaluation centers add to its program an evaluation unit which will provide the kind of services now provided by the existing work evaluation centers.

10 Objective: Funds should be allocated for recreational specialists in a small number of counties (perhaps three) who would work with existing recreational programs and activities in an effort to develop or improve existing, on-going recreational services provided for developmentally disabled individuals. Projects should utilize all community resources, private and public.

Rationale: Existing recreational services are fragmented. There is little assistance available at local levels for developing a well coordinated set of programs suitable to developmentally disabled people. Larger local communities need a recreational coordinator who can relate specifically to the needs of the developmentally disabled population and utilize all community resources, private and public, in an effort to expand and improve on-going programs.

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11 Objective: Funds should be used to stimulate and support new recreational programs and activities during the coming year.

Rationale: Recreational services are needed by most of the developmentally disabled population and available for less than half of those who need it. At the same time that it is important to coordinate and expand existing programs and bring them into a state-wide service system, it is also important to fund on a short-term basis new programs and activities which will meet the needs of developmentally disabled clients.

12 Objective: Funds should be used to sponsor a pilot sibling training program which would integrate with the currently operating parent training program.

Rationale: Parent training programs are now being established in various places in the state. The model does not particularly address itself to sibling training although sibling training is undertaken for specific children when necessary. This objective proposes a pilot sibling training program to determine its feasibility.

Approved Objective: The Mental Health Division should continue to allocate monies for the conduct of third party evaluations of funded projects.

Rationale: Evaluation is necessary in order to monitor program effectiveness. Unless funds are allocated for this purpose, however, good evaluations are not likely to be obtained.

Approved Objective: Funds should be allocated for a training program for developmentally disabled people and/or their families on self advocacy (self representation) as it applies to membership on boards and committees, or direct contact with agencies and the community as a whole.

Rationale: Developmentally disabled people should have a voice in decisions that are being made regarding their individual programs and the delivery of services as a whole. Traditionally, third party advocates represent the interests of the developmentally mentally disabled population. The goal of advocacy, however, is the development of each person's ability to represent his own interests. Currently there is no program that addresses this goal directly. We prefer that a program be developed which would train developmentally disabled people and/or their families in the skills and awarenesses they need to be their

Priority	
Approved	own advocates. This should include their participation in committees and consumer groups as well as their individual relationships with serving agencies and the community.
Approved	Objective: Funds should be allocated to training for service coordinators. The training proposal should include a needs assessment component in order to ascertain the most critical present needs of service coordinators for in-service training.
	Rationale: Three years of experience in the field of service coordination has allowed the Mental Health Division and the service coordinators to more clearly describe the potentials and problems of the program. At this time the service coordinators are in a position to benefit from a training program. We prefer that a training program be provided with specific objectives related to the job as it now is being implemented.

Short-Term Funding Objectives

Funding Rank	Mean	Frequency					Reordered	Merit Rank
		4	3	2	1	0		
1	2.65	9	3	4	0	4	X	6
2	2.85	8	6	3	1	2		2
3	2.85	8	4	6	1	1		1
4	2.80	6	8	3	2	1		7
5*	1.95	4	2	8	1	5		10
	2.70	6	7	4	1	2	X	5
6	2.60	7	6	2	2	3		9
7	2.42	6	2	5	2	4		12
8	2.25	5	3	6	4	2		8
9	1.95	3	5	5	2	5		15
10	1.75	4	2	5	3	6		14
11	1.65	3	2	5	5	5		13
12	1.50	2	2	7	2	7		16
**		7	7	3	1	2		3
**		1	2	1	6	10		11
**		2	0	4	3	11		4

*Two recommended objectives combined

**Approved for priority funding by generic agency.

Legislation
Committee Objectives

Priority

1 Objective: The Socio-Legal Task Force shall develop a plan for assuring the civil rights of developmentally disabled people, including the right to due process and equal protection.

Rationale: With legislative convening in January, 1975, it is of critical importance that advocates for the rights of developmentally disabled citizens be prepared to suggest, support, and lobby for legislation related to personal rights including the right to vote, the right to due process, and the right to protection under the law. We prefer that the Socio-Legal Task Force develop a plan for influencing such legislation.

2 Objective: The State DD Council should encourage legislation which would allow severely handicapped children and adults ipso facto to qualify for Children's Services Division and Public Welfare Division services (respectively) regardless of economic status.

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Rationale: At present Children's Services Division and Public Welfare Division can only assist those who are economically eligible. Individuals who are severely handicapped, whether they be severely retarded. severely multiply handicapped, severely crippled or severe autism cases, require a great deal of expense and care as opposed to less handicapped developmentally disabled people. This almost invariably becomes an economic burden on the family. It is therefore recommended that legislation be proposed that would allow all severely handicapped populations to be economically eligible for Children's Services Division and Public Welfare Division funds.

3 Objective: The State DD Council should actively support intent of the proposed Special Education legislation Task Force recommendations for education for the handicapped in the areas of due process and equal educational opportunities.

Rationale: This is sound legislation which proposes to: (1) consolidate all special education programs under one statute, thereby easing administration and funding and improving a child's mobility among programs suitable to his needs; (2) allow for certification of a child's eligibility for special programs, rather than requiring him to be certified as a handicapped child; (3) make the Superintendent of Public Instruction directly responsible for setting standards for institutional educational programs; (4) provide parents with a due process hearing before placement, transfer or denial of placement of their child; (5) provide for a new excess cost reimbursement formula.

Priority

4 Objective: The State DD Council should encourage the development of legislation which specifies division responsibility for setting standards and assuring the education of institutionalized people. The appropriation of adequate funding for the implementation of such legislation should be encouraged.

Rationale: At present, no division or person has the clear responsibility for setting standards or establishing educational programs in the institutions. Mental Health Division apparently does not, and a recent Attorney General's Opinion ruled that the Oregon Board of Education does not have this responsibility. We prefer that this be clarified through legislation.

5 Objective: Funds should be appropriated by the legislature to the Health Division for expansion of screening programs, particularly the development of Well Baby Clinics in counties that do not yet have them.

Rationale: It is important that broad based screening programs, especially those that serve infants, be available in close proximity to all major communities. The expansion of programs providing the services is dependent on the appropriation of adequate funds. We recommend the request for funds be actively supported.

6 Objective: In order to assure the provision of social services within group homes, legislation should be developed that will strengthen the collaboration among Human Resources agencies for the implementation of group care standards. The goal of such legislation would be to assure that the regulations governing group care are enforced in regards to the provision of social services as well as the maintenance of health and safety.

Rationale: Group Home regulations, as they are being proposed, attend to the provision of training programs and social services as well as health and safety. Assurance of compliance for all elements in the regulations is best maintained through the cooperative efforts of all relevant agencies.

7 Objective: Adequate funding should be provided through legislation for the education of institutionalized school aged children. Specifically, local districts should be required to contribute the per capita cost of the district for each child placed in the institution from that district.

Rationale: Educational programs in the institutions are currently substandard primarily because sufficient funds are not available for necessary staff. We prefer that cost be partially supported by local districts.

Priority

8 Objective: Funds should be appropriated by the legislature for the expansion of diagnosis and evaluation services through Crippled Children's Division and Child Development Centers specifically in Mental Health Region 3.

Rationale: Diagnosis and evaluation services need to be extended into the eastern part of the state. Funds must be appropriated at a level that will allow for expansion by diagnosis and evaluation agencies. The expansion of services should be sufficient to provide regular, frequent, and readily accessible diagnosis and evaluation to developmentally disabled people in areas not now served.

9 Objective: Sufficient funds should be appropriated to Public Welfare Division, Mental Health Division, Children's Services Division, Crippled Children's Division, and Vocational Rehabilitation Division to assure the purchase of necessary social services for clients currently in group care facilities and for the projected number of institutionalized clients eligible to be released for community placement during the 1975-77 biennium.

Rationale: The concept of community group home care carries with it the involvement of the client in a broad array of ancillary services. It is not a residential service only. The supportive social services, such as day care programs, recreation, and transportation, must be provided if the clients' placement is to be successful. Funding must be available to provide necessary social services.

10 Objective: Additional funds should be allocated to the Public Welfare Division and Mental Health Division to provide activity center experiences to all developmentally disabled clients needing them.

Rationale: The availability of activity center services to clients who need them is dependent on the ability of Public Welfare Division to provide support. Additional funds must be appropriated so that the service can be extended to more of those who need it.

11 Objective: Additional funds should be provided to the Public Welfare Division and the Mental Health Division for the establishment of new activity centers especially in Mental Health Regions 1 and 3.

Rationale: Mental Health Regions 1 and 3 have a disproportionately low share of activity center services. There are many clients in both regions who need these services. Development of new facilities depends on the availability of funds from the Mental Health Division and the Public Welfare Division.

Priority

12 Objective: The state Developmental Disabilities Council should support the inclusion of evaluative components in any legislation regarding education for developmentally disabled people.

Rationale: In order to monitor the effectiveness of programs for the developmentally disabled and to insure accountability for that effectiveness, legislation which supports programs for developmentally disabled people should include a provision for evaluation. This provision should include adequate funding for evaluation.

13 Objective: Local official and state legislators should be encouraged to pass legislation which encourages the inclusion of developmentally disabled individuals in recreational programs as part of any on-going programs in local recreational and community centers.

Rationale: As citizens of the state, developmentally disabled people are entitled to benefit from publicly supported programs. Any public agency or facility providing ongoing recreational programs should be required to make those programs available to the handicapped people.

14 Objective: The State Developmental Disabilities Council should encourage the legislated allocation to Mental Health Division of sufficient funds for conducting state-wide evaluation of parent training specialists programs.

Rationale: This is the enabling legislation to allow for a state-wide evaluation of parent training specialists by a third party evaluator. This is a new program and needs a careful examination to determine its feasibility for continuation and extension.

15 Objective: The State Developmental Disabilities Council should support the allocation of additional funds to Mental Health Division for the support of parent-training specialists throughout the state and for the provision of living unit parent training in the institutions.

Rationale: The provision of adequate family training programs as they are needed throughout the state depends on supportive funding. We recommend that enabling monies be provided to further the use of parent training specialists throughout the communities and for the training of living unit parents in the institutions.

Priority

Rejected Objective: Legislation should be enacted to broaden the range of treatments which can be paid for under the Medicheck program.

Legislation

Committee Objectives

Priority	Mean	Frequency 4	3	2	1	0	Reordered
1	3.84	16	3				
2	2.62	12	1	2		6	X
	2.55	9	3	3		5	X
3	3.65	14	5	1			
4	3.50	12	7		1		
5	3.43	11	8	2			
6	3.38	12	5	4			
7	3.35	10	7	3			
8	3.33	10	8	3			
9	3.29	12	3	6			
10	3.19	12	5	2		2	
11	3.05	10	3	7	1		
12	2.90	11	5	1		4	
13	2.80	7	7	2	2	1	
14	2.71	7	5	7		2	
15	2.48	7	6	3		5	
Rejected		2	2		3	14	

*Two recommended objectives combined.

Data Collection
Committee Objectives

Priority

1 Objective: Mental Health Division should continue the development and implement a uniform data collection system for monitoring services to developmentally disabled clients. The system should be implemented by the end of this fiscal year.

Rationale: Effective planning, budgeting, and monitoring the delivery of services require continuous feedback about the quantity, quality, and effectiveness of the services being provided to developmentally disabled clients. At the present time, the state has no uniform data collection system. We prefer that such a system be developed and implemented by the Mental Health Division.

2 Objective: All agencies providing educational services should be required to collect and report data as to the number of developmentally disabled children being served by type of disability and functional ability. Data should be made available to the state Developmental Disability council's data management committee.

Rationale: It is necessary to determine how many developmentally disabled people in the community require service in order that planning can be updated and improved concerning educational services to these children. We prefer that the data be collected by agencies providing services and that the data be available to planning bodies.

3 Objective: Diagnosis and evaluation agencies should monitor the extent to which the recommendations made in the client program plan are carried out and the effectiveness of those plans. Documentation should be based on follow-up with the agencies to which clients are referred. This data should be provided to the Mental Health Division for purposes of planning, budgeting, and affecting the quality of services.

Rationale: In order to plan for the delivery of needed services, it is important to know the extent to which recommendations of the diagnosis and evaluation services are or can be carried out. This information is not now available. We prefer that implementation of client program plans be monitored routinely.

4 Objective: The Mental Health Division should make available to the State Developmental Disabilities Council on an annual basis data on the number of families receiving parent training through parent training specialists, the Teaching Research Core Clinic, Crippled Children's Division, cooperative home-school models, and other programs.

Priority

4 Rationale: Data regarding the number of clients receiving a service is essential to planning. It is appropriate for the Mental Health Division to collect data on parent training being conducted through the state since programs for which they are accountable, parent training specialists and the Teaching Research Core Clinic, are providing the bulk of parent training. We further request that the Mental Health Division obtain from Crippled Children's Division information about parent training. Assuming that the TMR programs remain under Mental Health Division jurisdiction, information about cooperative home/school models should also be available.

5 Objective: The Children's Services Division and Public Welfare Division should systematically document the number of developmentally disabled clients receiving foster care services and the locations of homes providing foster care to developmentally disabled people.

Rationale: The Children's Services Division and Public Welfare Division provide foster care services to their respective eligible populations. Data are not available at the state level regarding the utilization of foster care homes for clients who are developmentally disabled. The data are necessary in order to assess the availability of the service and to plan for appropriate placement of clients. The use of foster care homes for developmentally disabled clients and the locations of homes which are able to receive developmentally disabled clients should be monitored by the agencies that purchase the service. The data should then be made available to the Mental Health Division for planning purposes.

6 Objective: All state agencies providing services to developmentally disabled clients should make available to the State Developmental Disabilities Council on an annual basis data as to the effectiveness of programs.

Rationale: The usefulness of services provided to developmentally disabled clients is measured by how effective the services are in helping each client to achieve his potential for an independent and constructive community life. An evaluation of effectiveness of services is extremely important to agencies which plan for expansion and improvement of services. We prefer that agencies responsible for provision of service develop mechanisms for evaluating program effectiveness and made that information available to planning bodies.

Priority

7 Objective: Beginning this year, the Public Welfare Division, Health Division, Board of Education, Crippled Children's Division, Children's Services Division, Division of Vocational Rehabilitation, Oregon Employment Division and Mental Health Division should document developmentally disabled clients receiving counseling services through their programs according to disability and presenting problem.

Rationale: There is no interagency system for monitoring the extent to which counseling services are provided to developmentally disabled clients. In order to plan for the expansion of existing counseling services or the development of new ones, it is necessary to know where services are currently being provided and the characteristics of clients receiving services. Many agencies are involved in counseling with developmentally disabled clients. Those agencies should provide the minimal baseline data needed for planning. The data should be collected in the same or similar format across all agencies.

8 Objective: Community Mental Health Programs should report systematically to the Mental Health Division the number of developmentally disabled individuals utilizing local emergency bed provisions (re SB 448). The Mental Health Division should establish the format and time frame for reporting by the Community Mental Health Programs, and the Division should make an annual report available to the State Developmental Disabilities Council.

Rationale: Senate Bill 448 requires that Community Mental Health Programs assure the provision of local emergency respite care beds. No data have been collected state-wide regarding the use of the emergency respite care beds. For the purposes of planning, budgeting, and affecting quality of care, documentation is needed on the number of developmentally disabled people utilizing the provision. We recommend that Mental Health Division be responsible for the collection of data through the Community Mental Health Programs.

9 Objective: The Mental Health Division should make available to the State Developmental Disabilities Council data on the priorities for the distribution of training funds within the institution specifically as it relates to training for living unit parents in support of school programs.

Rationale: In order to carry out realistic planning for developing services, it is important to have information about the priorities of training and the distribution of training funds within the institution relative to the training of living units parents. It is believed that an examination of how much money is being

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Priority

9 allocated to this particular subject would indicate the appropriateness or feasibility of implementing a living unit parent training program. It would also be valuable to have the actual results of the training that is provided now.

10 Objective: The number of developmentally disabled individuals or families of developmentally disabled people receiving homemaking services should be documented by Public Welfare Division as to the disability of the individual or family member and the primary type of service rendered (training, respite, health related, crisis, regularly scheduled).

Rationale: Homemaking services are provided by Public Welfare Division to a limited extent. No data have been available statewide on the number of developmentally disabled clients served or the type of service being rendered. Documentation of this information is important in order to evaluate the impact of expanding the service to more clients in more areas of the state. We recommend that Public Welfare Division be responsible for monitoring the program.

11 Objective: The Parks and Recreation Department, the Board of Education, and the Mental Health Division should identify specific recreational programs coordinated by local agencies for developmentally disabled children or adults in Oregon. Documentation should be made available to the State Developmental Disabilities Council by June 1975.

Rationale: There is no information available at the state level as to the number or locations of recreation programs for developmentally disabled people. We prefer to have this data available through appropriate state agencies and provided to the state Developmental Disabilities Council for the purposes of planning and evaluating.

Data Collection

Committee Objectives

Priority	Mean	Frequency 4	3	2	1	0
1	3.62	15	4	2		
2	3.57	14	5	2		
3	3.33	11	8	1		1
4	3.30	9	8	3		
5	3.29	11	7	2		1
6	3.24	10	6	5		
7	3.20	9	8	1	2	
8	3.04	10	4	5	2	
9	3.00	9	6	4	1	1
10	2.95	7	7	6	1	
11	2.62	7	4	6	3	1

Study
Committee Objectives

Priority

1 Objective: A study should be made of the total need for the various types of group care facilities throughout Oregon to ascertain where facilities should be located and how many people need different levels of residential care. The study should also determine the appropriate staff/client support ratios; related costs; and the effectiveness of programs in relationship to client needs.

Rationale: New community based residential facilities must meet the needs of developmentally disabled people by providing programs suited to varying levels of independence. They must also be placed where there is a demonstrated need for group care facilities. Geographic distribution should be such that facilities are located in close proximity to the clients' own communities. There are little data at this time related to needed levels of care and geographic distribution. We prefer that decisions on placement of new facilities be guided by statistical data about the needs and locations of the clients who will be served. In setting up group care homes, operators must make decisions related to staff/client support ratios, costs related to care provided, and client programming. Currently there are not data available to assist them in this decision making. We believe that a guideline or model is important so that the new facilities being established can offer a sound, realistic, and effective program for clients.

2 Objective: The criteria for eligibility for SSI payments and the impact of the criteria should be studied as to its effect on community placement and services that can be rendered by the Public Welfare Division.

Rationale: Eligibility for Supplemental Security Income payments determines eligibility for many other services, particularly those offered by Public Welfare Division. There is indication that some people who have been declared ineligible for SSI on the basis of IQ score have low community adjustment skills and are very much in need of other services. They are, nevertheless, ineligible for needed services because of the application of SSI criteria. We think that the criteria for SSI eligibility and its impact on other services rendered should be studied.

3 Objective: During the next year a study should be made as to the availability of treatment services to developmentally disabled adults. A plan should be prepared for the implementation of programs which are more readily available to the adult developmentally disabled population and should include medical services, dental services, speech therapy, physical therapy, occupational therapy, and psychotherapy.

Priority

3 Rationale: It appears that treatment services are not readily available to many developmentally disabled adults; however, sufficient data are not available to plan responsibly for the expansion of services. We prefer that a study be made of the existing programs providing treatment services and that, based on the study, a plan be developed for appropriate expansion of service.

4 Objective: A study should be made of the types of preparation being offered to students of counseling and clinical psychology in the state system of higher education regarding their work with developmentally disabled clients. A study should be made of the types of preparation being offered to teachers through the state system of higher education regarding their work with developmentally disabled people.

Rationale: The evaluation information and the incidence information that will be developed through other studies may provide information which will have impact upon university preparation of teachers. With this in mind a study should be designed that will work with university preparation agencies and discuss with them modifications of their training programs. Little is known about the type or appropriateness of training being provided to potential counselors. In order to plan for the expansion or development of future services it is necessary to know the skills that will be available in the manpower pool. It may also be necessary to affect the types of training being offered.

5 Objective: During the next year a joint committee of representatives from the State Department of Special Education, Crippled Children's Division and the Mental Health Division should conduct a study for purpose of developing a single coordinated program of services for handicapped children in need of both educational and therapy services.

Rationale: As of this time, little data has been collected concerning the availability of therapy services to children and the coordination of therapy services with the educational programs now provided to handicapped children. We prefer that a study of these related services be made and that a plan of coordination be developed by and for the concerned agencies.

6 Objective: A study should be made of the appropriateness of placements in nursing homes and the level of community support services needed for those persons placed in nursing homes.

Priority

6 Rationale: Nursing homes provide a community residential service to clients who need a high level of care and supervision. The clients also need training and community related activities that are suited to their level of ability and independence. In order to plan for the delivery of out-of-home support services for nursing home residents, data are needed on the types of programs that clients need, the methods used to make the programs available to the clients, and the number of nursing home clients who can be served through each type of program.

7 Objective: A study should be conducted concerning the functions of counseling and the ways in which it is being provided through the Community Mental Health Programs and other agencies with attention being given to the frequencies and types of problems presented and how the problems are being resolved.

Rationale: Last year Community Mental Health Programs provided counseling services to 1198 mentally retarded people, but no information is available about the types of problems treated or the treatment modes used. We believe that a study of the Community Mental Health Programs' counseling services is necessary in order to understand the types of counseling being provided and the types of counseling needed.

8 Objective: A study should be made of the need for and the under-utilization of respite care services available through the State Hospital and Training Centers and the Community Mental Health Programs (re SB 448).

Rationale: The provision of out-of-home respite care services by State Hospital and Training Centers was initiated last year in response to a strong out-cry from consumer groups as to the need for such a service. During the last year the service was utilized by one (1) person. This gross under-utilization of a service should be studied from the perspective of those people who perceived and spoke for the need.

9 Objective: A study should be made of the impact of licensure and certification of group homes on the effectiveness of services for clients in group care.

Rationale: The criteria for licensure has not been tested as to its adequacy. Only after the criteria are applied and studied can the effect of the licensure criteria on the quality of care be evaluated. A study should be begun soon after the regulations are implemented.

Priority

10 Objective: A study should be made of the impact of local zoning ordinances and other local regulations on the placement and development of group homes.

Rationale: Local zoning ordinances and other municipal regulations often restrict the development of group care facilities. More facilities need to be established to meet the needs of developmentally disabled clients around the state. Information must be available to those who are responsible for assuring the provision of community residential care as to the limitations and allowances of local ordinances which affect the placement of group care homes. As such information is collected, ways may be delineated for using and working with existing regulations, or efforts may be made to change them.

11 Objective: Work evaluation and adjustment training procedures for developmentally disabled clients need to be studied.

Rationale: Work evaluation procedures do not seem to be effective for many developmentally disabled people. The methods used in evaluating seem to be sufficiently difficult for clients to manage that some clients leave the program before evaluations are completed. Some clients are lost from programs during work adjustment training. Reports from one service coordinator indicate that the drop-out rate is high enough to warrant a thorough study of the procedures with the goal of suggesting modifications.

12 Objective: A study should be made of the educational programs in institutions concerning the extent and quality of programs in meeting prescribed standards.

Rationale: The institutionalized population has in general been somewhat neglected by the Developmental Disabilities Act except to assist in programs which will facilitate deinstitutionalization. Nevertheless, a large number of developmentally disabled individuals are still in institutions and require good educational programs in that setting. We recommend that a study be made, examining the educational programs in institutions once prescribed standards for those educational programs have been established. Until the establishment of prescribed standards, efforts should be made to gather information which would contribute to the establishment of standards.

Priority

13 Objective: A study should be made of the agencies currently providing diagnosis and evaluation in order to determine the depth and scope of services provided. This information should then be used to determine which programs can most beneficially be expanded through the use of public funds.

Rationale: Agencies which provide diagnosis and evaluation services conduct their assessments in a variety of ways, using different methods to evaluate different aspects of development. The composition of multi-disciplinary teams varies from agency to agency. Various types of diagnosis and evaluation are needed. The needs of a client may be better met through one type of assessment than another. We prefer that the types of diagnosis and evaluation being offered through the major facilities, including Crippled Children's Division, Child Development Clinics, Salem Evaluation Center, Center for Neurologically Impaired Children, and the Diagnosis and Evaluation Section of Mental Health Division be studied as to depth and scope of services.

14 Objective: During the next year a study should be made of recreational programs already in existence. A comprehensive model including standards for developing and implementing coordinated programs should be prepared from the study and disseminated to areas which need help in getting started. The study should consider the appropriateness of defining client outcomes.

Rationale: Currently no model is available which offers guidelines for the development and implementation of recreational program plans. If such a model were provided, many communities could begin to improve the quantity and quality of services to developmentally disabled people. A study of coordinated recreational programs which are currently operating in one or two locales may allow for the description of a usable model.

15 Objective: The relationship and roles of various agencies in regards to services coordination should be studied.

Rationale: Services coordination is provided by many agencies at this time. The proliferation of this activity may or may not be in the best interest of the clients. We prefer that the provision of services coordination by a variety of agencies be studied in terms of the impact on the client and the appropriateness of duplicating services and cost.

Priority

16 Objective: A study should be conducted of local Community Mental Health Advisory Boards and/or local Developmental Disabilities Councils regarding the affiliations of members, and their planning efforts for developmentally disabled clients with respect to the scope and impact of their plans.

Rationale: Different agencies and committees which are responsible for planning at the local level construe their roles differently. In planning for developmentally disabled people they demonstrate varying degrees of concern for consumer involvement. They show different degrees of attention to the private sector of service delivery. Some types of planning focus primarily on state budgetary demands; other types attend more to community development. We would like to know how local planning is being done, who it tries to affect, to what extent it is responsive to the concerns of developmentally disabled people.

17 Objective: A study should be conducted with the assistance of the on-going diagnosis and evaluation programs to document gaps in the spectrum of needed services. The study should identify what services are needed for carrying out client program plans and determine the extent to which the services are available to unavailable in or near the clients' communities.

Rationale: While diagn[illegible]is and evaluation services may be available, treatmen[illegible]follow-up programs do not regularly occur. Often pla[illegible] not implemented because resources are not available or [illegible]e resources are available, the responsibility for seein[illegible]ecommendations are carried out is not systematically [illegible]red. We prefer that information be gathered about the factors [illegible]t facilitate or hinder the implementation of client program plans so that systems can be developed that will assure the easy movement of clients from diagnosis and evaluation to needed services.

18 Objective: A study should be made of speech therapy programs for DD adults as they are presently being offered. A plan for the development of speech therapy programs for adults should be described and a process for implementation of this plan be recommended.

Rationale: Data are not currently available regarding speech therapy services for adults. A study needs to be made of existing programs to determine the extent to which new programs are needed and to plan for their development where appropriate.

Study

Committee Objectives

Priority	Mean	Frequency 4	3	2	1	0	Reordered
1*	3.38	13	5	1	2		X
	2.67	7	6	4	2	2	
2	3.19	11	5	3	2		
3	3.14	9	8	2	2		
4*	2.65	5	7	5	2	1	X
	2.75	7	5	4	3	2	
5	3.05	11	6	1		3	
6	3.00	10	3	6		2	
7	2.90	10	4	3	3	1	
8	2.90	7	8	3		2	
9	2.86	8	7	3	1	2	
10	2.76	8	6	3	2	2	
11	2.76	5	7	8	1		
12	2.72	8	5	4	2	2	
13	2.72	7	7	3	2	2	
14	2.67	5	6	8	2		
15	2.62	8	6	2	1	4	
16	2.57	6	6	5	2	2	
17	2.57	5	8	4	2	2	
18	2.52	6	5	7		3	

*Two recommended objectives combined.